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V. 87 #1



THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

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Partnership for Health



**Governor's
Conference
on
Health
Stresses
Comprehensive
Planning**

(See page 2 and following)



GOVERNOR'S CONFERENCE ON HEALTH

REMARKS BY GOVERNOR DAN MOORE
AT GOVERNOR'S CONFERENCE ON HEALTH
Thursday, January 25, 1968—11:00 A.M.
Memorial Auditorium — Raleigh, North Carolina

Thank you for coming today for this Conference on Health. I believe that this meeting will be a landmark in North Carolina's continuing effort to protect the health of its people and to provide adequately for the care and treatment of its sick and infirm. The public and private health-oriented organizations represented at this Conference have cooperated through the years to provide for improvements in health care programs for the people of this State.

In one sense, we have every reason to be thankful for the progress made in recent years in protecting the health of the people. Considerable gains are evident within our own lifetimes. Sanitation, once a major health concern, now is taken almost for granted. Many of the serious communicable diseases have been conquered. Medical treatment and hospital facilities have improved considerably and are more readily available to the people. And, the expected life span of man has increased by almost 20 years.

In another sense, however, it is most evident that we cannot become complacent. Infant mortality rates in the United States are substantially higher than in many other advanced countries, and the rates in this State are among the highest in this country. Rejection of North Carolina military inductees for health reasons occurs with greater frequency than in many other States. The costs of medical care continue to climb adding increased hardship to many in need.

The purpose of this Conference is to focus attention on these and other medical and health problems. I also want to report to you of our efforts to promote, protect, and conserve the health of the citizens—an essential factor in the total development of North Carolina. And, I want to ask for your support and your help in a new effort to coordinate the utilization of health resource to the end that every man, woman and child in this State has the finest in health care.



Of course, concern for the health of the people is nothing new for us. North Carolina pioneered in the Better Health Movement during the 1940's and has never ceased its efforts to improve services. Under the leadership of the State Board of Health, an excellent system of local public health services has been developed.

During this biennium a total of \$800,000 was made available in State aid to local health departments. At the State level new programs are being implemented which will insure quality care in the transportation of the sick and injured and in genetic counseling. Existing programs for the control of salt marsh mosquitoes, for the inspection of food and lodging establishments and for the dental care program were strengthened.

The fine system of local hospitals is a credit to many people who worked on the local, State and Federal levels under the coordination of the North Carolina Medical Care Commission.

North Carolina now ranks 12th from the top among States in the number of hospitals and 15th in the number of hospital beds. The State ranks 7th in the nation in the number of hospital beds constructed and 3rd in the number of Public Health Centers developed under the cooperative financing program.

North Carolina has at Chapel Hill the only State-supported medical center in the South, with major professional schools for medicine, dentistry, nursing, public health and pharmacy.



A total of 271 students is preparing for health careers at Chapel Hill and other medical centers under State scholarships for medical and paramedical studies. Over 100 rural communities have benefited by the services of students receiving these State scholarships.

Our system of mental health services, developed under the direction of the State Board of Mental Health, is recognized as being one of the finest in the country and is providing a pattern for other States.

Appropriations for mental health are at an all time high this biennium with a total of \$110 million going to provide care in the State mental hospitals and community mental health programs. Cost accounting programs have been implemented in the psychiatric hospitals and programs for alcoholism, mental retardation, and for prisoners in the State corrections system have been supported vigorously.

Even with the assistance of the Medicaid program, many States do not yet provide the health services to welfare recipients as does the State Board of Welfare.

During the past year payments to hospitals for the care of indigent patients were increased and rate increases were made for domiciliary and nursing home care for adult welfare recipients. The department is actively supporting cooperative programs in family planning throughout the State. Overall at least 1,100 fewer persons are now on public assistance rolls today than there were a year ago. The State is presently moving ahead with detailed advanced planning for the provision of better medical services to this decreasing group through the implementation of Title XIX of the Social Security Act.

The Vocational Rehabilitation Division of the Department of Public Instruction is nationally recognized for its rehabilitation programs. And, we believe that a comprehensive study presently under way will bring about further improvements in vocational training for the handicapped. Environmental health continues

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Guest Ed.—Edwin S. Preston, M.A., LL.D.



Governor Moore & Mrs. Sue Jones of
Medical Care Commission.

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January, 1968

No. 1

to receive special attention from the Department of Air and Water Resources, the State Board of Health, the Department of Agriculture and other agencies.

The Medical Division of the Commission for the Blind has increased and expanded its medical eye services, and last year 531 persons were rehabilitated to gainful employment by this agency. This represents an increase of 75 over the previous year.

The biennial budget approved by the 1967 General Assembly provided expenditures totaling over \$124 million for health and hospitals. In addition, sizeable State allocations for health-related programs were provided for welfare, education, public safety, correction, and other special areas. Some of 45 State agencies are involved. The total expenditure of State Government in the health care field during the present biennium will be more than \$150 million. This represents a sizeable increase over similar expenditures for the last biennium, and demonstrates the commitment of the State to providing for the health care of its citizens.

These State programs and others which I have not mentioned complement a network of health services provided by private organizations, voluntary health agencies, and many, many dedicated individuals. Certainly, without this total effort, the five million people of North Carolina would not have the health and the medical well-being that they do today.

It is evident, however, that we in North Carolina have a great opportunity to move forward rapidly in providing better health and medical services. Tremendous advancements are being made. All may not be as dramatic as the recent heart transplants, but all are important to better health and longer life. The people of this State deserve the advantages that modern science and concern can provide. And, while we cannot disregard the costs, we must not let them overshadow our purpose.

These same factors, of course, are applicable to other State services. It was this broad concern for greater coordination of State resources and better utilization of Federal and State funds that led to my creating the State Planning Task Force early in the Administration. It is significant that one of the first studies undertaken by the Task Force dealt with State health services. This initial work by the Task Force, in effect, gave North Carolina a head start in health planning for the future.

We were ready to move ahead when Congress enacted legislation providing for comprehensive health planning. Public Law 89-749. I designated the Director of the Department of Administration as the State official to work in implementing

(Continued on page 10)



Advisory Council for Comprehensive Health Planning.



Mrs. Annie B. Edwards, who retired January 1 of this year after 48 years of service with the State Board of Health, during which she was secretary to four State Health Directors. She is shown being presented a certificate of appreciation by Dr. Jacob Koomen, State Health Director.



Upon his retirement from service with the State Board of Health, Dr. J. W. R. Norton received a Certificate of Appreciation from Dr. Jacob Koomen, State Health Director. Dr. Norton served for 17½ years as North Carolina's State Health Director.

Retiring employees representing 409 years of service with the State Board of Health were honored at year's end in a special formal ceremony at Raleigh.

Dr. Jacob Koomen, the State Health Director, expressed the appreciation of the fellow workers in public health to the sixteen persons who retired at the end of December. They averaged a quarter of a century in service to North Carolina through public health. The ceremonies were held in the John H. Hamilton Auditorium of the Laboratory Building of the State Board of Health.

Mrs. Annie B. Edwards, Local Health Division, who entered on her duties in 1919, and has 48 years to her credit, led the list in length of service. She served as secretary for four State Health Directors. Not far behind was Marcus C. Allen, Laboratory Technician in the Serology Section, with 43 years to his credit. Charles M. White, Chief of the Insect and Rodent Control Section, Sanitary Engineering Division, had 34 years of service.

Also retiring was Dr. J. W. R. Norton, former State Health Director.

Other retirees with their length of service and Department are: C. E. Harrington, Laboratory Division, 32½ years; William Murray Linker, Jr., Sanitary Engineering Division, 31½ years; Oris Harris, Administrative Services Division, 30 years; Miss Amy Fisher, Local Health Division, 28 years; Edna R. Jackson, Laboratory Division, 27 years; Mrs. Wilma H. Harrell, Epidemiology Division, 25 years; Mrs. Golda Walker, Administrative Services, 23 years; Miss Doris Tillery, Local Health Division, 18½ years; Eugene E. King, Sanitary Engineering Division, 15 years; R. F. Hill, Sanitary Engineering Division 15½ years; Miss Lena E. Simmons, Administrative Services, 10 years; Jesse W. Harrell, Sanitary Engineering Division, 8 years.

State Board

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From the left, seated — Mrs. Annie B. Edwards, Golda Walker and Miss Amy Fisher. Standing — Eugene E. King; R. F. Hill; W. Murray Linker.

ff Who Retired January First — s Service Is Represented



Edna Jackson; Mrs. Wilma H. Harrell; Miss Lena Simmons; Miss Doris Tillery; Mrs.
tus S. Allen; Dr. J. W. R. Norton; C. E. Harrington; Oris Harris; Jesse W. Harrell;
and Charles M. White.

this legislation. He, in turn, established an office of health planning which could function in close liaison with the State Planning Task Force and other State agencies. Dr. Charles Cameron of the School of Public Health at the University of North Carolina at Chapel Hill was granted a leave of absence to become the director of the Office of Comprehensive Health Planning.

To assist Dr. Cameron in the designing of a preliminary plan for planning, a Technical Committee on State Health Planning and Health Services was established. It consisted of the heads of the Department of Health, Mental Health, Welfare, Public Instruction, and Personnel; the Medical Care Commission; the State Planning Task Force; and the Division of Health Sciences of the University of North Carolina. Their plan of study was submitted to the Public Health Service in the fall and was approved October 31, 1967.

The Office of Comprehensive Health Planning has moved ahead in preparing to initiate the program of study and planning. To advise and assist the Office in its work, I am pleased today to announce the appointment of an Advisory Council which, by law, includes a majority of consumers of health services as well as representatives of the major health interests of the State. Members of the Council are:

Clifton M. Craig, Commissioner, Department of Public Welfare, Raleigh
Grady Ranson Galloway, Executive Director, Commission for Blind, Cary
James A. Graham, Commissioner, Department of Agriculture, Raleigh
Dr. Eugene Alexander Hargrove, Commissioner, Department of Mental Health, Raleigh.

William Freeman Henderson, Executive Secretary, Medical Care Commission, Raleigh

Dr. Jacob Koomen, State Health Director, Board of Health, Raleigh

C. Arden Miller, Vice Chancellor, Health Sciences, University of North Carolina at Chapel Hill

George Eugene Pickett, Director, Department of Water and Air Resources, Raleigh

Dr. Henry Stuart Willis, North Carolina Sanatorium System, Chapel Hill

Dr. Andrew Arthur Best, Greenville

Herbert Clarence Bradshaw, Durham

Dr. Amos Summer Bumgardner, Charlotte

Senator Albert J. Ellis, Jacksonville

William Harry Entwistle, Jr., Hanes Corporation, Winston-Salem

James Clyde Gaither, Sr., Gaither's Restaurant, Inc., Brevard

Mrs. Foy T. Goodin, President, North Carolina Extension Homemakers Association, Newton

Mrs. Geneva Bass Hamilton, Goldsboro

Thomas Royster Howerton, Wilson

Robert Earle Jones, Agricultural and Technical State University, Greensboro

State Representative Ernest Bryan Messer, Canton

Dr. John Duncan Robinson, Wallace

Wayland J. Sermons, Washington

Carl Wilson Anderson, School of Social Work, University of North Carolina at Chapel Hill

Dr. William George Anlyan, Duke University Medical Center, Durham
 William Charles Barrett, The State Bank, Laurinburg
 Reverend Cecil Bishop, Trinity AME Zion Church, Greensboro
 Senator John R. Boger, Jr., Concord
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 Thomas Hightower Collins, Chapel Hill
 Thomas C. Day, Vice President, Citizens Bank and Trust Company, Hayesville
 Reginald Morton Fountain, President, North Carolina Association of County
 Commissioners, Tarboro
 George Watts Hill, Durham
 Dr. Frank W. Jones, Newton
 Mrs. Mary Edith Rogers, Gaston County Health Department, Gastonia
 Carlos Lowery Young, Shelby
 State Representative Kenneth C. Royall, Jr., Durham
 Alonzo Clay Edwards, Hookerton
 Mrs. William Francis Wolcott, Asheville
 Mrs. Joseph M. Hunt, Jr., Greensboro
 Charles Curtis Johnson, Jr., R. J. Reynolds Tobacco Company, Winston-Salem
 Mrs. Phebe Harlan Emmons, President, North Carolina Council of Women's
 Organizations, Raleigh
 James Gwyn Gambill, West Jefferson
 Rabbi Joseph Asher, Greensboro
 Roger Hester Sloop, Warren's Drug Store, Rural Hall
 Dr. John Gentry Martin, Boone
 Charles Scott Venable, Jr., North Carolina Tuberculosis Association, Raleigh
 John Alexander McMahon, President, North Carolina Blue Cross and Blue
 Shield, Inc., Chapel Hill

I am pleased to appoint Mr. John A. McMahon as Chairman, and Mrs. Phebe H. Emmons as Vice Chairman.

These members of this Advisory Council have assumed a most important responsibility. Their duties include:

- Advising the Governor, the Department of Administration, and the Office of Comprehensive Health Planning in the conduct of a comprehensive planning program for health.

- Assisting the Office of Comprehensive Health Planning in the identification of problems, needs and developments both within the State and elsewhere which relate to our efforts to provide comprehensive health services to the citizens of North Carolina.

- Recommending to the Governor, the General Assembly, the various boards and commissions dealing with health-related programs and private and public organizations, courses of action relating to the health needs and resources of the State.

- Facilitating communication and cooperation among agencies, organizations, professions, and the public in the cause of better personal and environmental health for North Carolinians.

The work of this Advisory Council will be instrumental in the development of a State comprehensive health plan under the provisions of Public Law 89-749 —the Partnership for Health amendments to the Public Health Service Act. An award of \$67,000 has been made to finance the initial steps for this fiscal

year. The comprehensive study plan for health services in North Carolina is designed to serve four major purposes.

1. It will provide for a comprehensive and coordinated approach to health planning with emphasis on the long-range investments which the State must make in such areas as health manpower, health facilities, and in the financing of health services. The study will help identify the underlaps and overlaps in the current spectrum of health services available in North Carolina.

2. It will provide access to the health planning process for consumers as well as a wide range of providers of health care.

3. It will provide for a new and more effective relationship among health and health-related groups.

4. It will provide for a strengthening of State and local decision-making in the health field through the comprehensive approach to health planning and through greater flexibility provided under the grant programs.

In addition, this approach to comprehensive health planning will facilitate the coordination of work by the various State agencies now active in the health care field with each other and with the numerous agencies in the private sector. And, it will also improve the communication between health planners and those with responsibilities in other areas essential to the total development of our abundant resources in North Carolina.

There is much to be considered by this Advisory Council. As I indicated earlier, vast progress is evident in health and medicine. But, there is a definite need for greater effort in many areas. There is often a gap between the potential for modern health care and the practice. And, unfortunately, not all citizens have the means or even the initiative to obtain good health care. Costs are increasing, medical and health manpower is more difficult to find, and adequate medical services are not readily available to all citizens. One of the early and high priorities facing this Council is a definition and projection of health manpower needs in order that the educational institutions in this State can make plans to fulfill these needs.

Study needs to be given the availability of health services in our less populated areas, particularly in the East and the West. Deficiencies must be identified and recommendations made for their correction. The growing metropolitan areas have special problems which must be given attention. The complexity of agencies and services for health care often are confusing and difficult for the would-be consumer to identify. Clarification and simplification are necessary.

Attention must be paid to the need for home health services, rehabilitation facilities, nursing homes and other services for the aged and chronically ill. Special services for school age children and emergency medical services for people injured in accidents must be given consideration. Increasing costs will mean increasing problems for the low wage earner and those on welfare. Ways must be found to insure that all have access to adequate medical care.

There is an urgent need for a coordinated program of recruitment, development and placement of health manpower. Attention must be given to the distribution of available health manpower to areas of need with emphasis being given to insure its full and proper utilization. The means must be found for a greater exchange of views and greater understanding between the health services consumer and the provider. Programs to minimize and eliminate environmental health hazards must be stepped up.

This advisory Council must give careful attention in its planning to insure close coordination and cooperation among all agencies and organizations involved in health services. It is evident from the challenges confronting North Carolina in this area that we cannot afford the luxury of unnecessary duplication. The numerous State agencies involved must join together with a new unity of purpose. And, the State must work hand in hand with local and Federal governments, private health-related organizations and individuals to get the necessary jobs accomplished.

Ladies and gentlemen, today marks the beginning of a great new effort on the part of North Carolinians to insure the finest in health and medical care for all. It is a massive undertaking. Its size, however, is diminished by its importance. The burden of responsibility for the preparation of this Comprehensive Health Plan for the future is not limited to the Advisory Council named today. Nor is it limited to the Office of Comprehensive Health Planning and the various State agencies and departments which will contribute.

Success in the planning phase, as in implementation, depends upon the active thought and participation of all concerned with the good health and well-being of their fellowmen. Your assistance, your suggestions, your participation are essential in the development of this Comprehensive Health Plan. We have an opportunity in North Carolina today to move ahead in planning for the attainment of the highest levels of health service for all citizens. With your help, we can succeed in planning and in providing a total health program second to none.



Mrs. Kitty Ellington received the annual, much-coveted Outstanding Service Award from Glenn Flinchum, president of the Public Health Academy.



Albert J. Klimas, who has been serving as Director of the Cabarrus County Health Department since October. Klimas is 37, a native of West Virginia, who completed his work for the M.S.P.H. degree from the University of North Carolina. He came to the North Carolina position from Colorado where he was Assistant Chief of the Chronic Disease Section of the State Department of Public Health.

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Theodore D. Scurletis, M.D.	<i>Director, Personal Health Division</i>



Stephanie Crane, Teenage Easter Seal Chairman

Brown-haired, green-eyed Stephanie Crane, who was crowned Miss Teenage America before a nationwide television audience last November, has been named National Teenage Chairman for the 1968 Easter Seal Campaign, Mar. 1 to Apr. 14.

Stephanie, who turned 18 in December, is from High Ridge, Mo., a suburb of St. Louis, and she is a senior with a B-plus grade average at Cor Jesu Academy in that city.

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DATES AND EVENTS

- March 1-2 — Health Careers Congress, Robert E. Lee Hotel, Winston-Salem
- March 1-3 — American Association of Pathologists & Bacteriologists, Chicago
- March 6-7 — NLN Regional Conference, Atlanta, Ga.
- March 7 — 3rd Annual Wilson Memorial Hospital Postgraduate Symposium, "Heart Disease in the Child and Adult," Wilson, N. C.
- March 11-13 — National Health Council, Los Angeles
- March 11-13 — 14th Annual Sectional Meeting for Nurses and Doctors, American College of Surgeons, Williamsburg, Va.
- March 18-20 — American Academy of Pediatrics, Atlanta, Ga.
- March 21-22 — Annual Convention North Carolina League for Nursing, Blockade Runner, Wrightsville Beach, N. C.
- March 22-23 — Annual Convention Student Nurse Association of N. C., Blockade Runner, Wrightsville Beach, N. C.
- March 22-23 — 2nd National Congress on the Socio-Economics of Health Care, The Palmer House, Chicago, Ill.
- March 25-28 — 6th Annual Meeting for Registered Nurses, Sponsored by Southeastern Surgical Congress, Sheraton Park Hotel, Washington, D. C.
- April 3-5 — 4th Annual Migrant Health Conference, Reidsville
- April 4-6 — 3rd National Conference on Health Education of the Public, Pick Congress Hotel, Chicago, Ill.
- April 19-20 — Population Association of America, Boston, Mass.
- April 19-20 — American College of Surgeons, Blockade Runner, Wrightsville Beach
- April 21-22 — Annual Meeting, N. C. Conference for Social Service, Sir Walter Hotel, Raleigh
- April 30-May 1 — Tuberculosis Association Annual Meeting, Heart of Charlotte Motel, Charlotte, N. C.



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Lori and Lisa Yauch, 4-year-old identical twins, are 1968 National Easter Seal Children. The daughters of Mr. and Mrs. Gail Yauch of Detroit, the girls both are victims of cerebral palsy resulting in spastic paraplegia. But, with the help of skilled physical and occupational therapists at their Easter Seal treatment center, they are learning to overcome their handicap and preparing themselves for the demands of life.



THE LONGEVITY OF DECEASED AMERICAN PRESIDENTS, VICE PRESIDENTS, AND CANDIDATES FOR PRESIDENT

	Presidents		Vice Presidents	Unsuccessful Candidates for President*
	All	Excluding Those Assassinated		
Average Number of Years Lived.....	68.5	70.7	70.4	70.1
Pre-Civil War	74.2	‡	67.4	72.3
Post-Civil War	63.4	66.6	72.2	68.5
Average Years Lived Above or Below				
Expectation of Life at Inauguration†....	- 3.6	- 1.5	- 2.6	- 2.2
Pre-Civil War	+ 1.3	‡	- 4.0	+ 0.3
Post-Civil War	- 7.9	- 4.8	- 1.8	- 4.0

*Includes only those receiving some electoral votes.

†According to mortality conditions prevailing at that time; in the case of unsuccessful candidates, at the time of inauguration had they been elected.

‡No Presidents were assassinated during this period.

Statistical Bulletin, Metropolitan Life Insurance Company, September 1967

The North Carolina Human Betterment League: An Idea Come of Age

By Chester Davis

The North Carolina Human Betterment League, which celebrated its 20th anniversary this past year, is less important as an organization than as a symbol of an idea that has come of age.

When the league was organized in 1947, birth control concerned a handful of zealous reformers like Margaret Sanger and a very few, far-sighted men who suspected that Thomas Robert Malthus just might be right. Elsewhere there was either powerful opposition—that of the Catholic church, for example—or a public distaste for open discussion of such untidy matters as contraceptives, sterilization and abortion.

Opposition Wavers

While the opposition continues, it appears to be wavering. The traditional Catholic position on birth control is challenged now by growing and increasingly articulate forces within the church. And public distaste promises to become a relic of our prim Puritan past. The freedom with which we now discuss **the pill** and related matters is a measure of the change that has taken place. It is change born of reality—the reality of the population explosion which is no longer a prospect but a fact.

Demographers report that when men and women first began experimenting with the geometric progression of birth it required half a million years or so—until about 1650, they say—for world population to reach the half billion mark. Then, in 200 years, it doubled, passing the billion mark by 1850.

It doubled again in the next 100 years. By 1966, world population was put at 3.4 billion. The demographers estimate that by 2000—34 years away—there will be 6.8 billion people on earth.

This has consequences which translate into terms of numbers and quality.

The Least Able

The problem of quality results from the fact that the least fit are doing most of the breeding. In international terms, it is the so-called developing nations of Africa, Asia and Latin America which have the highest birth rates. These, of course, are the nations least able to feed their populations, much less their projected populations.

In terms of individuals, the quality problem results from the fact the birth rate is the highest—about two to one—among those least qualified for parenthood; the mentally, physically, genetically, (and, for these reasons, the economically) scrub stock. As William Penn noted, we breed horses and dogs with greater care than we breed human beings. The long-range implications are not pleasant.

The problem of sheer numbers—a problem now growing at the rate of 60 million a year—has even more immediate and distressing implications. It will determine, for example:

—How much we will have to eat.

—The quality of our standard of living.

—The degree and rapidity in which we foul our environment with our own wastes.

The economic cost we pay because of our inability to check the run-away birth rate has not been totaled. It undoubtedly is staggering, because it includes the cost of famine, air and water pollution, and growing public health and public welfare costs.

We have reached the crossroads Malthus predicted for us. Either we check the world's birth rate immediately and substantially or it will be done for us by what he described as the three ultimate population controls: War (probably nuclear), famine and epidemic disease.

In 1947, when the North Carolina

Rules and

Regulations

Governing

Ambulance

Service

Copies of Rules and Regulations governing Ambulance Service of the North Carolina State Board of Health, adopted October 12, 1967, are available on request, as a Supplement to the North Carolina Health Bulletin from the Accident Prevention Section, Division of Epidemiology, North Carolina State Board of Health, Raleigh, North Carolina 27602.

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Guest Ed.—Edwin S. Preston, M.A., LL.D.

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No. 2

Human Betterment League was organized, the focus was on the problem of quality more than number. Dr. Clarence J. Gamble of Milton, Mass., a geneticist who built an international reputation at both Harvard University and at the University of Pennsylvania, was particularly concerned with genetic and economic folly in human breeding.

Draft Rejectees

In the period immediately after World War II, Gamble became intrigued by North Carolina's startling rejection rate (14 per cent in 1942 and 48 per cent in 1944) of draftees for reasons of mental illness or mental retardation.

At Gamble's instigation, Miss Else Wulkop, a medical social worker, came to the state to explore the facts behind these statistics. With the assistance of Dr. A. M. Jordan, an educational psychologist at the University of North Carolina, the intelligence level of the school children of a rural county (Orange) was tested.

The results of this test caught the eye of James G. Hanes, then president of the Hanes Hosiery Corp. Hanes asked that a similar study be made of the children of an urban county. This was done in Forsyth County.

The results of the two studies—each reflecting an alarming incidence of mental problems, both illness and retardation—was combined with additional data gathered by Miss Wulkop and resulted in the formation of the Human Betterment League in 1947. It was the first of a number of such leagues. Its essential purpose, then and now, was to educate the people of the state regarding the need for an effective, intelligent program of birth control and to instruct them regarding the tools — and the use of the tools — of birth control.

Broadens Emphasis

Initially, the league emphasized the quality by concentrating on programs calculated to curb births, control the least fit. More recently the league has added its voice to those of similar organizations around the world to preach the need to control human numbers lest we breed ourselves out of standing room.

During its formative years, the league pushed for more effective use of the state's Eugenics Law.

This law, adopted in 1933 and since amended, creates a Eugenics Board which consists of the secretary of the State Board of Health, the commissioner of public welfare, the attorney general, the chief medical officer of the State Hospital in Raleigh and one other medical officer from a public mental institution elsewhere in the state.

The board, operating on a limited (\$25,000 for the 1964-66) budget meets quarterly to pass on cases proposed for selective sterilization by the directors of the state's hospitals for the mentally ill and retarded and from the superintendents of the various county public health departments.

The Eugenics Board can order sterilization in four types of cases:

- Where it is in the best interest of the patient, mentally, physically or morally.

- Where the operation is ruled to be in the public interest.

- Where there is a request made by the guardian of a mental patient.

- Where hereditary mental or physical ailments are likely to be transmitted to the child.

Appeals from the board's orders to the courts are possible, but they are uncommon because the cases are carefully selected.

The operation is simple. For males

(the vasectomy), it consists of cutting and tying off the tubes through which sperm moves. For women (the salpingectomy), it consists of cutting and tying the fallopian tubes through which the egg moves.

In terms of sex, these operations have only one effect; they forever prevent conception. The sex function itself is not in any way impaired. In fact, studies suggest that sexual gratification more often than not is enhanced because of the removal of the fear of pregnancy.

From 1934 until 1947, when the league was formed, a total of only 1,827 sterilizations had been performed under the state law: 1,214 patients were feeble-minded, 385 insane, and 228 suffered from epilepsy and other hereditary afflictions.

In 1947 this state ranked 17 among the 27 states having similar laws. Since then, and largely because of the educational work done by the league, North Carolina rather regularly has led other states in protective sterilization.

Even so, the number of cases—an average of something like 250 to 300 a year—processed under the state's eugenics program is not large. It is likely to increase somewhat in the immediate future because the 1963 General Assembly amended the Eugenics Law to remove the possibility of a surgeon performing protective sterilization being held guilty of mayhem, an ancient felony that has come down to us out of English common law.

Moreover, the sterilizations performed under the Eugenics Law represent less than 10 per cent of the total sterilizations performed each year in this state. A 1959 study of 83 hospitals in North Carolina indicated that an average of 2,880 tubal litigations (protective sterilizations) were being performed each year. More than 90 per cent of these were voluntary, and most of them

were done for the convenience of the patient and because the patient was unable to risk the burden and cost of more children.

Results of Studies

Studies indicate that for every 100 feeble-minded women (and 200 men) who undergo this operation the birth of 90 retarded children is prevented each year.

The social and economic consequences of this are apparent.

The program helps reduce the birth rate among the least fit. And, according to the record, the term "least fit" has no racial connotation. Sterilizations under the Eugenics Law rather closely follow the white-Negro ratio of our population.

The program also reduces welfare and health costs. Equally important, it protects unfit parents from the crushing burdens of family, and at the same time insures against the tragedy that results when a child of normal intelligence is born to retarded or insane parents.

In recent years, as the league's interests came to encompass the sheer number of our birth rate as well as the quality of the children being born, emphasis has been placed on local family planning clinics.

North Carolina was the first state to include birth control—counseling about contraceptive devices—in its public health program.

It was not, however, until the formation of a family planning clinic in Mecklenburg County in 1960 that this program really began to roll.

Large-Scale Control

The oral contraceptive—the pill—greatly enhanced the prospects of large-scale birth control programs. By 1962, the Mecklenburg clinic had 99 women (each with a history of one to 12 pregnancies and none able to support a child) taking Enovid, an oral contracep-

tive which had proved highly successful in mass experiments in Puerto Rico. The cost was \$2 a month for each patient, and the director of the clinic said that in the first 13 months this program saved Mecklenburg taxpayers more than \$20,000. Equally important, it saved 99 women from burdens they were incapable of bearing.

In June 1964, thanks to spade work done by the league, by John McDowell, director of Forsyth's public welfare program, and Roger Sloop, a member of the local board of health, a similar clinic was established in Forsyth County. Administered by the Bowman Gray School of Medicine and directed by Dr. Henry C. O'Roark II, this clinic had 200 participants in its first four months. That pace has accelerated.

Similar clinics, few of them as large as those in Forsyth and Mecklenburg, now exist in some 90 local health and welfare departments in this state.

Attitudes Changes

This development reflects a fundamental change in public attitude in the past two decades. This is not peculiar to North Carolina. The same change is occurring elsewhere. It is seen in many ways. For example:

—Until recently two states—Massachusetts and Connecticut—had laws which forbade anyone, including physicians, from giving out information or devices related to birth control. The Connecticut law was declared unconstitutional by the U.S. Supreme Court in 1965.

—At the state level, the trend is toward removing blocks to effective birth control programs. In 1967, for example, the North Carolina General Assembly greatly liberalized this state's abortion law. There is accumulating evidence of all sorts to indicate that we are evolving a planned society. There are few areas where this evidence is as clearly seen

as in birth control.

—In 1959, Dwight D. Eisenhower said that birth control was not a matter that should interest the federal government. In 1963, in an article in the *Saturday Evening Post*, Eisenhower firmly, clearly changed his position.

—In fiscal 1966, the federal government spent \$4 million on birth control. The amount was doubled in 1967. In August of this year, the Department of Health, Education and Welfare established an office to administer birth control programs. In this same period, birth control was given increasing attention in anti-poverty programs.

More Interest

—Private foundations—the Ford Foundation for one—are becoming increasingly active in the family planning field.

—Last year, the United Nations for the first time took an unequivocal, strong position endorsing an all-out, international effort to control population.

This change results from two interacting causes: The dire predictions of Malthus have become realities; organizations like the North Carolina Human Betterment League—and there are now many of them here and abroad—have opened the eyes of the world to an alternative to the cruel and ultimate population controls, war, famine and plague. It is the alternative of controlling our numbers and their quality by the intelligent use of the birth control knowledge we possess.

Since 1948, the American Heart Association and its affiliates and subdivisions, such as the North Carolina Heart Association, have channeled more than \$120 million into research. The Heart Association is the largest source of non-governmental research support in the cardiovascular field.

Physician May

Treat Minor's

Venereal Disease

It has long been held in most states that a physician who treats a minor without parental consent—except in a medical emergency—may be liable to charges of assault and battery.

In North Carolina the attorney general ruled some years ago that "the situation when a person is infected with a venereal disease is quite different from that of other types of illness requiring treatment so far as a minor is concerned."

The law (Section 130-96) states: "state and local health directors, or authorized agents under their supervision within their respective jurisdictions, are hereby empowered and directed, when it is necessary to protect the public health, to make examinations of persons reasonably suspected of being infected with venereal disease, and to detain such persons until the results of such examinations are known, and to isolate or quarantine persons with a venereal disease when it is necessary to protect the public health. Persons infected with a venereal disease shall report for treatment to a licensed physician and continue treatment until the disease is no longer communicable."

In the attorney general's opinion "no parental consent is necessary for the physician's protection in administering treatment to a minor for a venereal disease because the above-quoted statute furnishes the physician complete protection."

Home Accidents Kill

Nearly 30,000 Americans were killed and well over four million others injured in home accidents in 1966. That's why the National Society for Crippled Children and Adults has launched an all-out campaign to call attention to home safety.

According to National Safety Council estimates, more deaths—some 40 percent—took place in bedrooms. But the greatest number of disabling injuries occurred in kitchens—well over a million persons were hurt in kitchen accidents during the year.

Major home accident categories, as detailed in the Easter Seal Home Safety Checklist, and the numbers killed during the year are as follows:

- **FALLS:** The greatest home danger is from falling. An estimated 11,800 persons were killed during the year, and many thousands more received disabling injuries.
- **FIRE:** A total of 6,800 persons died from fires, burns and related causes including asphyxiation, falls and falling objects related with home fires.
- **POISONING:** A total of 2,800 persons died from poisoning in the home. Common causes were medicines, household poisons, carbon monoxide.
- **SUFFOCATION:** Some 2,500 persons died at home from choking on ingested objects, smothering and strangulation.
- **FIREARMS:** Gun accidents killed 1,500 persons at home. Many took place while cleaning or playing with weapons.
- **OTHER:** Miscellaneous accidents claimed 4,100 lives in American homes, including drownings, electrical shocks and other accidents.

National Policy

For Elderly

Proposed

Establishment of national standards and goals for meeting the problems of older people in certain crucial areas was called for today by Milton J. Shapp, chairman of the public policy committee of the National Council On the Aging.

In testimony before the Special Senate Committee on Aging Mr. Shapp noted that many advances have been made since the first national conference on aging, held in 1950. He suggested that the "time has now come to establish some national standards and goals for the elderly in certain crucial areas—to measure the need, to define ways of meeting the need, to estimate the cost, and to establish target dates."

Among the specific recommendations made by Mr. Shapp, a Pennsylvania industrialist who was the 1966 Democratic candidate for governor of his state, were:

- launching of a national study to determine means by which federal support could be given to localities granting older people exemption from real estate taxes
- another national conference on aging, preferably by the end of 1969, to establish national goals, to make recommendations for public policy to realize these goals, and to give direction to studies and smaller meetings in advance of the conference

- preparation by the special Senate committee on aging of estimated needs and costs involved in such a national effort
- use of a consumer purchasing power index in establishing a price tag on the abolition of poverty.

Mr. Shapp noted that the social security benefit increases proposed would increase the minimum to \$840 a year for an individual and \$1,260 a year for a couple.

This would mean, he said, that the average social security benefit would still be slightly below the poverty level.

In urging abandonment of the "piecemeal" approach to problems of older people in favor of a national policy, Mr. Shapp said:

"These methods have brought results in war efforts, in space exploration, in public highway construction and—to an extent—in public education.

"We can do no less with regard to human goals for the older people of the nation.

"The elimination of poverty in old age," the NCOA spokesman said, "must have first priority as a national goal. It is now estimated that some five to seven million people over 65 in this country live in poverty. Forty percent of the women living alone or with non-relatives are poor. Non-white families are almost three times as likely to be poor as are the white aged of the same family status."

Mr. Shapp also emphasized the housing needs of older people noting that nearly three million older people in 1960 were living in dilapidated, deteriorating housing, hazardous to health and contributing to social breakdown. Nearly four and a half million dwelling units are needed to overcome the acute shortage of appropriate housing for the elderly.

Physical Changes May Explain Relapses In Drug Habit

The perplexing cycle of drug addiction, treatment, and relapse may be partially explained by physical changes in the body which compel addicts to resume their habit up to eight months after withdrawal.

New findings reported at the National Institute of Mental Health Addiction Research Center in Lexington, Kentucky show that morphine withdrawal causes two distinct phases of physiological changes in the body which may also alter behavior.

The physical effects of withdrawal were previously known to last only three or four weeks, but a series of studies in both rats and men indicates that the "withdrawal syndrome" may persist for up to 30 weeks.

These findings may partially explain why 90 percent of the addicts who relapse do so within six months after treatment. Relapse of addicts is a serious problem since some studies show that 80 to 90 percent of the treated addicts eventually return to the habit.

The new findings show that patients have lower than normal blood pressure, slow pulse rate, and low body temperature after about nine weeks of abstinence, which is the opposite of early effects of withdrawal. These symptoms, as well as a marked decrease in the respiratory center's sensitivity to carbon dioxide, last up to 30 weeks.

Immediate withdrawal of morphine produces severe physical reactions, although gradual reduction of the drug and the use of medications can make withdrawal easier for the patients. However, high blood pressure, rapid pulse rate, and high body temperature usually persist for three or four weeks.

Another related finding is the discovery of elevated levels of epinephrine in the urine of test subjects several months after withdrawal. Epinephrine is produced by the adrenal gland and may be liberated in excess quantities during stress.

In addition, studies in rats indicate that the withdrawn subjects have a greater "appetite" for drugs than non-addicted subjects for a long period after withdrawal.

The investigators, Dr. W. R. Martin and Dr. D. R. Jasinski, say that the findings suggest that dependence on morphine may cause changes in the central nervous system that last for several months and produce altered physiological functions, an altered psyche, and increased drug-seeking behavior.

Dr. Martin is the chief of the Addiction Research Center and Dr. Jasinski is chief of the opiate unit at the Center.

Run for Your Life or Jog — But Just Don't Sit There

"Run for your life—or jog—or walk—but don't just sit there!"

One hears this advice increasingly these days, and therefore the U.S. Public Health Service's National Center for Chronic Disease Control is engaged in examining what occurs if you follow those simple suggestions.

In support of the hypothesis that some form of habitual physical activity helps reduce the chances of having a heart attack, the National Center's Heart Disease Control Program is coordinating Center-sponsored physical exercise research programs, including projects at three State universities—Minnesota, Wisconsin, and Penn State.

At each of the universities exercise programs consist of walking, jogging or running, and calisthenics or modified game activities. All activities are supervised by trained personnel. Participation is on the basis of 45 minutes each day, three days a week. At Minnesota, men were selected at random from two of the local census tracts. At Wisconsin, the group consists of middle-aged professors, while at Penn State, participants include a cross-section of male university employees.

These projects were designed to answer several questions:

- What is the most effective way to identify individuals in the community who are at greater than average risk of developing coronary heart disease?
- What influences an individual's decision whether or not to participate in a physical activity program? And if he decides to participate, what influences him to continue to participate on a regular basis over a long period of time?
- What problems are involved in organizing and administering group physical activity programs?
- What effects does participation in physical activity programs have on a person's health in terms of reducing his

risk of developing a heart attack and in changing his health attitudes and health habits?

A long range goal of the overall research effort is the eventual development of coordinated physical activity programs in the nation's communities if future research demonstrates that increased physical activity reduces the number and severity of heart attacks.

The projects, now entering their second year of operation, are providing university scientists and Heart Disease Control Program specialists the opportunity to study the effects of various types of physical activity upon selected groups of individuals. Participating at the three universities are approximately 450 men between the ages of 40 and 59. As a group, all of these men were characterized by certain conditions or living habits that increased their chances of a heart attack. These include:

- Overweight
- High blood pressure
- High cholesterol content in the blood
- Cigarette smoking
- Lack of major habitual physical activity

In the studies, participants are divided about equally into two groups; one that exercises and one that does not. Periodically both groups are examined to determine what changes, if any, have occurred in their health status attitudes and habits.

Preliminary findings to date are encouraging. All three schools point to improvements in the general health of the exercise participants. At the University of Minnesota where the project has been in operation the longest, there has been among other things, considerable improvement in "heart rate response"—the ability of the heart to withstand increasing amounts of phy-

sical exertion at lower pulse rates. As one participant put it—"we aren't huffing and puffing as much as we used to."

Perhaps the most significant finding to date, however, is the conclusion that individuals can be encouraged to exercise on a regular basis over a continuing period of time, provided:

— They are properly oriented to opportunities for exercise and the possible health benefits to be derived.

— The type of exercise to be performed is determined, at least partially, by individual preferences.

Of major concern at this time is the question of whether the present exercise programs are sufficient to reduce the participants' risk of developing heart disease. Project directors also hope to find ways of motivating individuals to continue some appropriate type of exercise after they leave organized programs.

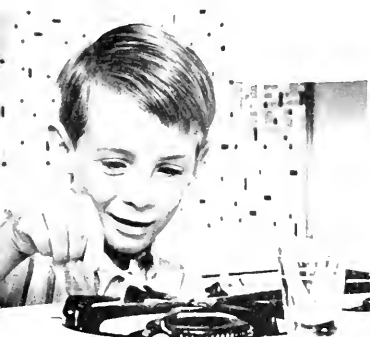
Dr. Bruno Balke, director of the University of Wisconsin project, believes the latter point may resolve itself, explaining:

"Many participants already are organizing their own exercise groups against the day when our project ends."

Dr. Balke, along with project directors at the other two universities, Dr. Henry L. Taylor, Minnesota, and Dr. Elsworth Buskirk, Pennsylvania State University, is convinced that data provided by the present series of projects will become foundation blocks in the long range efforts, not only to prevent heart attacks, but also to help victims of heart attacks to recover from them.

The doctor should be called immediately when a stroke occurs so that he can determine the proper individualized treatment for each patient, the North Carolina Heart Association advises.

EASTER SEAL HOME SAFETY CAMPAIGN



3



2



1. He's fascinated by fire, a major cause of home injuries. The Easter Seal Home Safety Checklist shows how to make your home a safer place to live.

2. She's heading for a fall, the cause of nearly 12,000 deaths last year and a major contributor to the nearly 4½ million disabling injuries. Get a copy of the Easter Seal Home Safety Checklist.

3. The medicine chest is a source of danger for younger children. The Easter Seal Home Safety Checklist will tell you how to protect your children from poisoning and other home threats.

THE NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS
2023 W. Ogden Avenue
Chicago, Illinois 60612

Senator Belk

Receives

Award

The American Cancer Society has awarded its 1967 Distinguished Service Award to Charlotte businessman and former Senator from Mecklenburg County, Irwin Belk. The award is the highest honor in the Society.

Belk is the immediate past president of the North Carolina Division, American Cancer Society, and has done volunteer work for the organization on both the local and state levels. At present he serves as Chairman of the Nominating Committee as well as a member of the Division Executive Committee. He also serves as Chairman of the Committee

to Study the Utilization of Local Facilities for the Improvement of Patient Care for the Governor's Cancer Commission.

President of Belk Enterprises, Mr. Belk is the ninth person to receive this award. Other recipients are Dr. Ivan Proctor, Raleigh; Judge John D. Larkins, Jr., Trenton; Dr. H. Fleming Fuller, Kingston; Dr. Donald B. Koonce, Wilmington; Dr. H. Max Schiebel, Durham; Dr. John R. Kernodle, Burlington; Dr. Paul Kimmelsteil, Milwaukee, Wisconsin; and Mr. John R. Jordan, Jr., Raleigh.

In recent years, population studies have developed a "coronary risk profile" for high-risk America, the North Carolina Heart Association reports. With its assistance, physicians can readily identify "coronary-prone" individuals years before open symptoms appear—and can suggest changes in their way of life or other measures to help ward off the potential heart attack or stroke.

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Heart Transplant Conference Held

The American Heart Association, in order to provide reassurance to the public and counteract any anxieties that heart transplant surgery might be premature, called a conference early this year in New York City to clarify its position on the advisability of this new surgical technique.

The panel discussing the question of heart transplants was composed of **Dr. Jesse E. Edwards**, President of the American Heart Association and Clinical Professor of Pathology at the University of Minnesota School of Medicine.

Dr. Michael E. DeBakey, head of the world's largest cardiovascular center at Baylor University College of Medicine, Houston, and renowned for his accomplishments in the development of mechanical boosting pumps to help faltering hearts; **Dr. John P. Merrill**, Director of the Cardio-renal Section, Peter Bent Brigham Hospital, Boston, and leading authority on kidney transplantation;

Dr. John H. Gibson, Jr., one of the developers of the heart-lung machine which has made possible open-heart surgery and, ultimately, heart transplants; **Dr. William L. Glenn**, Professor of Surgery at Yale University School of Medicine, developer of surgical procedures to relieve congenital defects, and a pioneer in pacemaker development; **Dr. Earl B. Mahoney**, Chairman of the American Heart Association's Council on Cardiovascular Surgery and a Professor in the Department of Surgery at Strong Memorial Hospital, Rochester, N. Y.; and **Dr. Lewis E. January**, Immediate Past President of Amer-

ican Heart Association, and Professor of Medicine at the State University of Iowa College of Medicine.

The 17th Southern Water Resources and Pollution Control Conference will be held April 16-18, 1968, at the University of North Carolina, Chapel Hill, North Carolina. This annual Conference is co-sponsored by the Department of Environmental Sciences and Engineering at the University of North Carolina, and Departments of Civil Engineering at North Carolina University and Duke University. The 17th Conference will feature presentations and discussions on the technology of water resources and water quality management with particular reference to the southeastern United States. A detailed program will be available about January 1, 1968. For additional information, please write to Dr. Charles M. Weiss, Chairman Operating Committee, 17th SWRPC Conference, Department of Environmental Sciences and Engineering, P. O. Box 630, Chapel Hill, North Carolina 27514.

Rachel D. Davis, M.D., prominent Kinston physician and outstanding civic and educational leader, was elected President of the North Carolina Division, American Cancer Society. She succeeds Senator Irwin Belk of Charlotte in this post.

Deaths caused by high blood pressure have dropped 52 per cent in the past 20 years for Tarheel men between the ages of 45 and 64. The North Carolina Heart Association says that advances in the treatment of high blood pressure, made possible by Heart Association-supported scientific research, is a major factor in this saving of lives.

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Dates & Events

April 21-22 — Annual Meeting, N. C. Conference for Social Service, Sir Walter Hotel, Raleigh

April 30-May 1 — Tuberculosis Association Annual Meeting, Heart of Charlotte Motel, Charlotte, N. C.

May 9-10 — Western Branch, N. C. Public Health Association, High Hampton Inn, Cashiers, N. C.

May 13-17 — Biennial Convention: American Nurses' Association, Dallas, Texas

May 15-17 — Meeting: 38th Annual Statewide Industrial Safety Conference, Jack Tar Hotel, Durham

May 16 — N. C. Association of Industrial Nurses, Durham

May 19-22 — Annual Meeting: National Tuberculosis Association, Houston, Texas

May 27-31 — Annual Meeting: Southern Branch, APHA, Roanoke, Va.

Migrant Projects

Fourteen migrant health projects, located in four states, have recently been awarded Public Health Service grants totalling \$1,797,812, Surgeon General William H. Stewart announced.

The grants, authorized by the Migrant Health Act, will be used to improve health services to migrant agricultural workers and their families. Projects will use these funds to provide family health service clinics, medical and dental care, nursing and sanitation services, health education, and in-hospital care.

Florida, a home-base area for many migrants, received the largest number of dollars, \$908,588. Projects in Texas, another home area, were awarded \$715,742. Colorado received \$149,339; Louisiana \$24,143.

One hundred and fifteen projects in 36 states and Puerto Rico are now receiving Public Health Service support. Grants are made to State or local public agencies and to non-profit private organizations, which are required to contribute part of the cost of the projects.



THE HEALTH BULLETIN

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1968 Distinguished Service Award

Eugene Benson Crawford and Elisha Merriman Herndon, senior vice presidents of North Carolina Blue Cross and Blue Shield, Inc., will receive the 1968 Distinguished Service Award of the North Carolina Hospital Association.

Selection of Mr. Crawford and Mr. Herndon to receive the award, which is given annually to an individual who has rendered outstanding service to the hospitals of North Carolina, was made by the NCHA Trustees.

The two veteran Blue Cross leaders, who have given outstanding encouragement to the concept of prepaid voluntary health care since the movement began in North Carolina in 1933, will receive their awards jointly at the annual meeting of the Hospital Association on June 25 at Wrightsville Beach.



Eugene Benson Crawford



Elisha Merriman Herndon



ARTHUR C. STERN APPOINTED TO UNIVERSITY OF NORTH CAROLINA FACULTY

Arthur C. Stern, presently Assistant Director of the National Center for Air Pollution Control, Washington, D. C. has accepted an appointment as Professor in the Department of Environmental Sciences and Engineering of the University of North Carolina School of Public Health. His appointment in the Air and Industrial Hygiene program of the Department was facilitated by the Institute for Environmental Health Studies at the University.

For all of his professional life, Stern has been in the air and industrial hygiene field. He was for thirteen years Chief of the Engineering Unit of the Division of Industrial Hygiene in New York State and for seven years was

Chief of the Laboratories of Engineering and Physical Sciences of the Division of Air Pollution of the Public Health Service at the Robert A. Taft Sanitary Engineering Center in Cincinnati. His educational background includes the M.E. degree in 1930 and the M.S. in 1933 from Stevens Institute of Technology.

Stern is listed in *Who's Who in America*, *Who's Who in Engineering*, and *American Men of Science*. He is also editor of the three-volume handbook "Air Pollution," published in its second edition this year.

Stern in his new faculty position will provide a very close tie between the University and the National Center for Air Pollution Control which is in the process of moving to the Research Triangle of North Carolina only a few miles from the University.

Nationwide

Cervical

Screening

Program

Saves Lives

Nationwide cervical screening projects, supported by the Public Health Service's National Center for Chronic Disease Control, are responsible for saving or prolonging the lives of thousands of American women, according to an analysis of Center reports covering a five year period starting in 1962.

Dr. William L. Roberson, Medical Officer responsible for review of the

screening projects, said that over one million cytology examinations had been made at various hospitals throughout the country and that cervical cancer was found in more than 6,500 women. More than 4,000 cases of carcinoma in situ were detected.

(Cancer in situ means that the malignancy is at "stage zero," and that there is no invasion of the normal adjacent tissue. If treated immediately and properly, such cancers are almost 100 percent curable.)

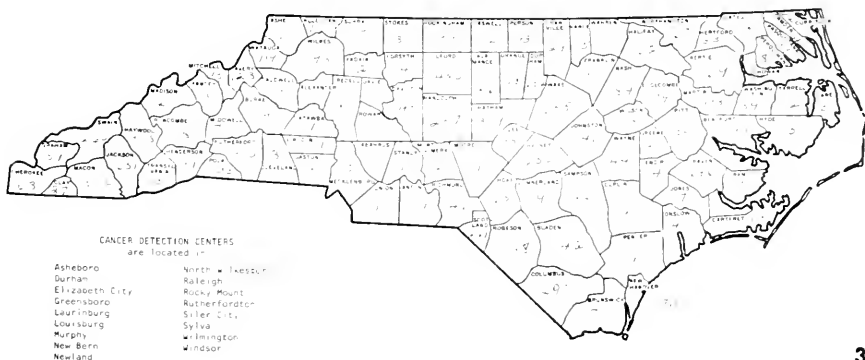
There are 143 grant-supported projects in 35 States, the District of Columbia, and Puerto Rico. Effort has been concentrated on the low socioeconomic groups because of their risk of cervical cancer.

Dr. Roberson pointed out that the Center's Cancer Control Program also supports the American Academy of General Practice in its "Office Detected Cervical Cancer Program," now embracing more than 4,000 physicians in 36 States and the District of Columbia.

The Academy Program has been in effect since 1965 and more than 546,000 women have been screened, about one-third of them for the first time. A total of 1,059 carcinomas have been detected—865 in situ and 194 invasive, according to latest available reports.

Cancer Detection in North Carolina

PERSONS EXAMINED IN CANCER DETECTION CENTERS
BY PLACE OF RESIDENCE - NORTH CAROLINA, 1967
Total persons examined - 2,551



The Center Program staff assisted in organizing the State academies for the study, Dr. Roberson said. The project calls for Pap examinations (a very simple cancer test).

All patients with suspicious or positive results are followed up to insure that they are diagnosed and treated if cancer is present. Those treated for cancer are scheduled for periodic checks to make sure the therapy is adequate and that there is no recurrence of growth.

"The Academy Program establishes the general practitioner's office as an appropriate facility for carrying out this cancer detection project," Dr. Roberson said. "It alerts the private physician to the need for adequate examination and follow-up. It shows there is an impressive number of undiagnosed cases among the female population. Its continuation and expansion will mean much to the general good health of our country," Dr. Roberson stated.

He added that the number of early cases detected and cured was highly significant and "supports our contention that cervical cancer can be controlled if all women will have a pelvic examination and Pap smear at least once a year."

Dr. Roberson estimates that about 26 percent of the women over 20 years of age in the United States were cytologically examined in 1966, up from 15 percent in 1963 and 10 percent in 1961. In comparison, Dr. Roberson pointed to British Columbia, a province of Canada, where the annual examination rate is about 65 percent.

All screening projects supported by the NCCD subscribe to certain standards such as tissue diagnosis, definitive treatment and adequate follow-up. In other respects, the projects are controlled and conducted by the institutions receiving the grants.

Indian Plants Studied in Cancer Drug Search

The Indian government's Central Drug Research Institute at Lucknow has renewed its agreement with the National Cancer Institute, National Institutes of Health, to study native Indian plants as a source of potential anti-cancer drugs. A U. S. Public Health Service contract, using blocked dollars available under Public Law 480, is providing \$136,000 (1,020,400 rupees) to finance the next 3 years of investigation.

Under the program the Indian research center, directed by Dr. M. L. Dhar, collects indigenous plants and from them prepares extracts for study by the National Cancer Institute in Bethesda, Maryland. Dr. Jonathan L. Hartwell, project officer for NCI and head of its Natural Products Section, has the extracts tested for their ability to inhibit animal cancers.

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Improved Endoscopes

Aid in Early Cancer

Detection

A contract for the development of five improved endoscopes for viewing internal organs of the body to aid in early detection of cancer has been announced by the Cancer Control Program of the National Center for Chronic Disease Control, Public Health Service.

Dr. William L. Ross, Chief of the Cancer Control Program, said the contract for development of the instruments is budgeted at \$149,222 and will require approximately 18 months. The contract was awarded to the IIT Research Institute, an affiliate of the Illinois Institute of Technology in Chicago.

The instruments will be flexible fiber optic probes for viewing the throat, larynx, bronchial tubes, stomach and a portion of the colon which will enable doctors to view the interior of the body without performing surgery. Cancers in these 5 sites will cause almost 100,000 deaths this year. The endoscopes also will assist doctors in diagnosing other diseases.

The contract calls for the development of new synthetic fibers instead of glass to transmit light around curves in the body organs. The probes also will have a mechanical system allowing maneuverability and control by the examiner. Though glass fibers are flexible, they are not flexible enough to prevent occasional breakage when probes are flexed into sharp bends. Poly-Optics Systems, Inc., Santa Ana, California, will join ITRI in fiber development.

Lighting the body's dark interior for examination will be achieved by sending light through one or more fiber

optic bundles. Another optic bundle will transmit a magnified image back to the examiner through an eyepiece. Several of the instruments will have a channel for extracting biopsy specimens and provision for washing the lens without withdrawing the probe.

Optical scopes for endoscopic examination (examination of hollow organs of the body) were first used over 75 years ago, but their usefulness has been limited because of inflexibility, large diameters, and optical shortcomings. The new family of instruments will permit viewing internal areas which have been "blind" spots or entirely inaccessible with former probes.

One glass-fiber endoscope for viewing the lower intestine, which was developed with CCP support, already has undergone tests at the University of Michigan Medical Center under the direction of Dr. Bergein F. Overholt (currently with New York Hospital, Cornell Medical Center, N.Y., N.Y.). Success achieved with the instrument, called a fibersigmoidoscope, prompted the proposed development of the family of five probes.

Camera attachments for the instruments will permit photographing through them during examinations. The probes will range in length from 15 cm. for the throat probe (laryngoscope) to 100 cm. for the stomach probe (gastroscope). Diameters will range from 6 mm. to 15 mm.

Medical consultants, in addition to Dr. Overholt, who will work with ITRI and the Cancer Control Program in developing the endoscopes are Dr. George H. Conner, Henry Ford Hospital, Detroit; Dr. Daniel J. Fall, University of Michigan, Ann Arbor; Dr. Jordon D. Haller, Maimonides Hospital of Brooklyn and State University of New York College of Medicine; and Dr. Marvin Pollard, University of Michigan.

The Problem of Atherosclerosis

The problem of atherosclerosis is one of the most crucial medical threats facing the civilized world today, states the North Carolina Heart Association. Year by year, the scourge of this disease becomes more evident and it knows no class, color, or race distinctions.

Excavation in the Nile Valley has indicated that even the Egyptian pharaohs of 2000 B.C. suffered from atherosclerosis.

Just what is atherosclerosis? Atherosclerosis, practically speaking, is the deposit of fat material, known as lipids, along the walls of the arteries and, more particularly, the vital vessels of

the heart, brain, kidneys, and extremities. These lipids, usually composed of cholesterol, slowly reduce the diameter of the veins and arteries, making the passage of blood more difficult. In time, these cholesterol deposits may become so great that a vessel or artery is blocked entirely.

The effect of atherosclerosis has often been likened to the problem encountered in old pipes in water systems. With passing years, corrosion and clogging often render pipes in a water system unuseable. When the arteries are blocked, depriving any given portion of the body of the blood and ensuing oxygen it needs to maintain life, death occurs in the portion so deprived.

Atherosclerosis is known to be the chief cause of coronary artery disease and of cerebral vascular accident (stroke).

Western NCPHA Meets at High Hampton Inn, Cashiers, N. C.

MAY 9 & 10, 1968

APPLY: RESERVATION MANAGER, HIGH HAMPTON INN, CASHIERS, N. C.
PACKAGE

RATES:

1.	\$12.18	(3 to a room)
2.	13.50	(2 to a room)
3.	15.75	(single room)

Package rates to include, lodging, buffet, banquet and dance, breakfast, and luncheon, including tax and tips.

NON-PACKAGE For those not staying at the Inn.
RATES:

Banquet and dance	\$5.00
Luncheon	2.50
Breakfast	1.50

Registration begins Thursday, 2-7 P.M. and Friday 8-12 Noon.

Registration is \$3.00. Wives and/or husbands of members and nonpublic health guests register gratis.

Older Americans Spend Five Times the Medicine Cost for the Young

Americans aged 65 years and older spent about five times as much for prescribed medicines in a one-year period as did young people aged 15-24 years, according to Wilbur J. Cohen, Acting Secretary of Health, Education, and Welfare.

Mr. Cohen said persons 65 years and older spent an annual average of \$41.40 compared to \$8.10 by persons aged 15-24 years.

He reported on a study which involved a nationwide sampling of the civilian, noninstitutional population by household interviews. Approximately 42,000 households were visited, comprising about 134,000 persons.

"The largest part of the average of \$41.40 spent by persons 65 years and older was \$7.10 for treatment of high blood pressure," Mr. Cohen said. The next largest amount was \$5.70 for treatment of heart conditions.

Women 65 years and older annually spent more on the average (\$46.70) than men (\$34.70) for prescribed medicines, Mr. Cohen pointed out. Women spent the largest part (\$9.70) for treatment of high blood pressure, followed by \$5.50 for treatment of heart conditions. Men spent the most (\$6.00) for treatment of heart conditions and \$3.90 for treatment of high blood pressure.

Prescribed medicines were defined in the study as: (1) medicines obtained by a physician's written prescription, including refills; (2) medicines prepared on the basis of a physician's telephone order to a pharmacist; and (3) medicines given by a physician or his assistant to a patient to take home.

The survey also obtained information

on costs and uses of nonprescribed medicines—those obtained without prescriptions, including pills, tonics, salves, ointments, and first-aid supplies. For nonprescribed medicines, Mr. Cohen noted that persons 65 years and older spent on the average the largest amount (\$2.30 per person) for aspirin and its compounds. The next largest amount (\$1.70) was used for vitamins by this age group.

Women 65 years and older on the average spent the largest part (\$2.60) of their expense for nonprescribed medicines to buy aspirin and its compounds, compared to \$2 for men in the same age group. Again, the second largest amount was spent on vitamins—\$1.80 for men and \$1.70 for women.

Automated Test for Heart Disorders in Babies

Doctors may one day call upon the computer to help detect heart disease in newborn infants and other young children.

An automated system for analyzing the pediatric electrocardiogram (ECG)—a test for heart disorders in babies and children—is being developed by the Public Health Service's National Center for Chronic Disease Control, under the direction of Dr. Lowell W. Perry.

"Each year an estimated 20,000 babies are born with congenital heart disease in the United States," according to Dr. Perry, chief of the Pediatric Section of the Center's Heart Disease Control Program. "Deaths among these babies most often occur during the period shortly after birth, especially during the first month of life. In addition, from one to two of every 1,000 school-aged children presently have undetected heart disease."

**Where the Eastern District NCPHA
Will Hold Its Annual Meeting
June 6-7 at Atlantic Beach**



**EASTERN DISTRICT NORTH CAROLINA PUBLIC HEALTH ASSOCIATION
ANNUAL MEETING
John Yancey Motor Hotel, Atlantic Beach, North Carolina
June 6 and 7, 1968**

Preliminary Program

**THEME: Viewpoints of Comprehensive Public Health Planning in North Carolina
Thursday, June 6**

Registration	1:00- 4:00 P.M.
First General Session	4:00- 5:00
Business Meeting	
Hospitality and Fun Session	8:00-11:00 P.M.

Friday, June 7

Registration	8:30- 9:30 A.M.
Second General Session	9:30-12:00 Noon
Presiding	J. S. Canady, President Elect

 Comprehensive Health Planning in North Carolina

 John Alexander McMahon, Chairman, Advisory Council on Comprehensive Health Planning; President, North Carolina Blue Cross and Blue Shield, Inc.

Ten Minute Break

 Panel: Public Health From Three Angles

 Moderator Dr. Jacob Koomen, State Health Director
 Management of Public Health Personnel

 E. Clark Edwards, Personnel Director, State Board of Health

 Current Trends in Public Health Personnel Administration

 Claude E. Caldwell, Director, State Personnel Department

 Public Health Outlook as Viewed by County Commissioners

 John T. Morrissey, Executive Secretary, North Carolina Association
 of County Commissioners

Section Meetings	1:30- 3:30 P.M.
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Third General Session	3:45
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 Reports and Announcement of New Officers

Fourth General Session	6:30- 7:30
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 Happy Hour

Buffet Banquet	7:30- 9:00
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Adjournment	9:00
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Dance	9:00- 1:00 A.M.
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That's What GRANDFATHERS Are Made Of

BY BERNICE JANE HERMAN

MY husband doesn't play the oboe, grow mushrooms in the basement or crossbreed guppies. He has no collections under glass, no enrichment hobbies. But he's not unsettled by semiretirement nor troubled about identity. He knows who he is and so do his grandchildren. He's a grandfather.

Right now the scoreboard reads eight, but this is an expanding market and precise tabulation may not be accurate. My husband doesn't fret. He's having a great time. "Who's coming today?" he frequently asks.

"Tommy," I answer, or Ellen or Bill, Matthew or Janie, Eric, John, Michael or any possible combination. Think of a name and we probably have it. If not, we will.

"Fine," he says and cancels appointments, declaring he'll stay home and help with the grandchildren.

This makes me purr as I sometimes feel engulfed when grandchildren visit in platoons. I welcome any help Grandpa can give.

What is the **why** of grandfathers? As babysitting fathers, many of them were absolute duds. They may have been good providers and tender husbands, but child care was woman's work.

My husband, faithful to the mores of his times, didn't dare to be a father. Only sissies pushed their own baby carriages. A man might push a neighbor's baby carriage if the neighbor was pretty, but an all-American husband didn't take care of his own children.

In those days husbands weren't conditioned by matriculation in and graduation from an expectant-parent course. They would have been frightfully discomfited bathing a naked doll in a basin in front of a coeducational class. They would have balked at homework that demanded studying a diaper-changing manual or instructions on how to time the labor pains.

Most of them were embarrassed by pregnancy. Not one of them discussed it on the commuters' train. If they encountered it on the street they looked the other way. Fatherhood overwhelmed and frightened them. If they confided their expectancy they avoided a declaration of truth and whispered they were expecting a "surprise." Many of them reacted with gross responsibility. They worked double time and became overcautious, overinsured, overinvested and overtired.

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Happily, those fathers make splendid grandfathers. They seem to know that what you do with children isn't as important as how you do it or what you say as important as how you say it. So they enjoy. My husband takes grandchildren to the fire station. He spends more time there than a stray cat. As a boy he liked to stand just inside the door of the fire station, petting the Dalmatian with the red eyes and feeling fascinated by the spic-and-span floor, the highly polished brass and the smell of horses in their stalls. Always he waited for the rare times when the fire alarm rang and the firemen slid down the poles while the harnesses, suspended from above dropped down on the horses.

Perhaps grandfathers have never stopped waiting for the clang to sound. Perhaps they want to be with their grandchildren when the fire bell rings and the firemen slide into their boots and ride away. Whatever the motivation, a grandfather's pleasure is pure. Sometimes it brings him an earned tribute.

Recently a fireman asked one of our grandsons, "What are you going to be when you grow up?"

This little boy looked up at the big fire engine, studied the coiled hoses and patted the dark shiny boots.

"I'm going to be a grandfather," he said.

Grandfathers are wonderful because they're natural. They have no facades. And they're not concerned with setting a good example. They are themselves.

Although they don't have to bandage bruised fingers or dress and feed grandchildren, they know how to prevent a crisis. When our grandchildren are tired my husband outmaneuvers ennui. He takes out his lower plate. The children are transported.

"Grandpa took out his teeth!" they report to everyone.

Sometimes grandfathers are what they are because grandchildren believe in them. Many years ago our oldest son told some of his playmates, "My father used to be a football player."

"Are you kidding?" they jeered. "That old man!"

Thirty-five years later the children we know best believe that Grandpa used to be a football player. "That's how he lost his teeth," one of these children explained to his friends.

Grandfathers might never have had time to be fathers but they take time to be grandfathers. They take grandchildren to the zoo, the circus, the ball game, the barbershop and the park. They read them stories and ride them piggyback. They love their grandchildren on a straight person-to-person basis without having to stumble over themselves.

That's why grandfathers are what they are.

John C. Lumsden Named Occupational Health Chief



John C. Lumsden has been named Chief of the Occupational Health Section, Epidemiology Division of the North Carolina State Board of Health, according to announcement by

Dr. Jacob Koomen, State Health Director.

Mr. Lumsden is known throughout North Carolina as a qualified and highly respected career public health worker who has devoted almost twenty years' service as Industrial Hygiene Engineer for the State Board of Health. He is a graduate of North Carolina State University and a member of a number of professional organizations, among which are the American Academy of Industrial Hygiene, the North Carolina Board of Refrigeration Examiners, the Governor's Council on Occupational Health, the American Industrial Hygiene Association, and the North Carolina Society of Engineers.

For a number of years, Mr. Lumsden has served as Chief Industrial Hygiene Engineer for the State Board of Health, during which period the Occupational Health Program has grown in scope and complexity. On July 1, 1967 he was appointed Acting Chief of the Occupational Health Section and has served in this capacity until his recent promotion to Section Chief.

Mr. Lumsden's long record of dedicated, efficient service and his outstanding ability to work harmoniously and effectively with people at all levels commend him to all who are interested in public health and assures a continuation of progressive growth for this important public health program.

Emphysema, The Battle to Breathe

What it means to have emphysema, a progressive lung disease, is the subject of "Emphysema, the Battle to Breathe," a new publication recently released by the National Center for Chronic Disease Control, U.S. Public Health Service.

"Emphysema, the Battle to Breathe," published by the Center's Chronic Respiratory Diseases Control Program, is a reprint of an award-winning five-part series written by Frank E. Carey, Associated Press Science Writer and carried by AP in September 1966. The series generated strong public interest in the fast-mounting and little understood problems of chronic lung disease.

"Emphysema, the Battle to Breathe" carries the reader into medical centers for the care and rehabilitation of emphysema patients and introduces actual patients, describing the way of life dictated by their breathing problems. The booklet presents what can be done for even those seriously crippled by the disease, to restore them to more useful and productive lives. Special attention is given to steps which the patient can be taught to clear his lung airways and to retrain breathing muscles, programs he can carry on in his own home. Mr. Carey's series also highlights research being conducted to uncover causes of chronic lung disease.

Single copies of "Emphysema, the Battle to Breathe," PHS Publication No. 1715, are available from the Public Health Service, U.S. Department of Health, Education, and Welfare, Washington, D. C. 20201.

Increasing Family Income Results in More Visits to Physician

The proportion of the female population with obstetric or gynecologic visits to a doctor in a one-year period increases sharply with increasing family income. Where family incomes are below \$2,000, only 2.8 percent have made such visits. At \$2,000 to \$3,999, 5.5 percent, and so on up to 12.5 percent at family incomes of \$10,000 and above.

For visits to a pediatrician the story is similar. At family incomes of under \$2,000, only 7.5 percent of the population under seventeen made such a visit in a one-year period. At \$10,000 and above the proportion was 33.0 percent.

The pattern of visits to a dentist is no different. Where family income was under \$4,000, the number of visits per person per year was 0.8. Between \$4,000 and \$7,000, it was 1.4 percent and so on up to 2.68 visits per person per year at family incomes of ten thousands dollars and over.

The relatively low figure of use by low income families is not due to fewer disease problems. The number of chronic conditions and the annual experience of days per person of restricted activity, bed disability, and time lost from work are marked greater for persons with low family incomes. When hospitalized the average length of stay is longer among the lower income groups.

Adapted From: The New England Journal of Medicine.

Script for Radio Program on Chronic Disease

This is Edwin S. Preston.

Our guest today is Dr. John Henry of the Chronic Disease Section of the State Board of Health.

1. Dr. Henry, what are the "chronic diseases"?

Dr. Preston, these are illnesses which cause disability over long periods of time. They include diseases of the heart, the lungs, the liver, and the kidneys and such diseases as cancer and diabetes.

2. Who is most likely to develop a chronic illness?

Well, actually, persons of all ages are susceptible to these illnesses, although certain ones such as heart disease and cancer are found more often in people over the age of forty.

3. Can any of these illnesses be prevented?

Yes, some of these can be completely prevented. Others can probably be prevented if certain risks for the diseases are recognized early and preventive measure taken. However, even in the ones which cannot be prevented, such as diabetes, it is very important to prevent complications and disability due to the illness, and these complications may be prevented if the disease process is diagnosed early in its course and the individual is put under the care of his physician.

4. Are methods available for detecting risks and early signs of chronic illness?

Yes, there are. First of all, individuals should have regular medical checkups by their physician, even when they don't feel sick. The physician's questions and physical

examination may reveal risks or signs of illness. In addition, multiple screening test programs or what we call "multiphasic screening" may assist the physician in his evaluation of the patient who feels healthy.

5. Multiphasic screening is an interesting term. What does it mean?

Well, multiphasic screening is the performance of a broad group of measurements and laboratory tests on an individual. Abnormalities in the results of these tests provide general indicators to help physicians track down risks of illness or unknown illnesses.

6. What tests are included in a program of multiphasic screening?

There are many possible tests for screening programs, but some of the basic ones include measurements of height, weight, blood pressure, and lung capacity, and examinations of the blood chemistries, a chest x-ray, a urine specimen, and a pap smear in women. Electrocardiograms, eyeball pressure readings, and certain other blood tests are desirable.

7. How does multiphasic screening help the physicians and his patients?

Screening tests provide additional in-

formation to give helpful clues to physicians in their regular care of their patients. It may help to bring patients to early treatment for certain illnesses. It should be emphasized that screening does not substitute for the physician's check-up, but attempts to provide extra information for such check-ups.

8. Is multiphasic screening being tried in North Carolina?

Several pilot programs in multiphasic screening are being conducted throughout the state. These screening programs are being conducted in local health departments or in a local hospital. Different groups of screening tests are being evaluated, and as pilot projects, the programs are being studied to determine how much unknown disease is being found. We believe many questions will need to be answered by these study programs, but we also think multiphasic screening offers tremendous opportunities in preventive medicine in the future.

Our guest has been Dr. John Henry, of the Chronic Disease Section of the State Board of Health.

This is Edwin S. Preston.

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Margaret Dolan Appointed Member of Health Insurance Benefits Advisory Council

Wilbur J. Cohen, Acting Secretary of Health, Education, and Welfare, announced the appointment of Charles L. Schultze, former Director of the Bureau of the Budget, as the new Chairman of the Health Insurance Benefits Advisory Council. Mr. Schultze is now Professor of Economics at the University of Maryland and Senior Fellow with the Brookings institution. He succeeds Kermit Gordon, whose term as Chairman recently expired.

The appointment of 6 new members was also announced, 3 to succeed members whose terms have expired and 3 appointed in accordance with recent legislation increasing the membership of the Council from 16 to 19.

Mrs. Margaret B. Dolan, professor and head of the Public Health Nursing, School of Public Health at Chapel Hill, is one of these new members.

The Council was appointed in November 1965, to advise the Secretary of Health, Education, and Welfare on matters of policy in the newly enacted Medicare program.

LSD Causes Opposite Moods

LSD characteristically causes opposite moods at the same time: one can feel tense yet calm, or serious but silly within the same few moments, scientists at the National Institute of Mental Health, U. S. Public Health Service, have found.

Dr. Martin M. Katz, NIMH psychologist and senior investigator, described major findings of the study. Scientists

selected 80 prison inmates of average intelligence who knew little about LSD as subjects in the project to pinpoint the drug's psychological effects.

The prisoners were given either 50 micrograms of LSD, dextro-amphetamine, or plain sugar pills. None knew which of the three he was taking. The subjects were then asked to answer a carefully designed questionnaire on their responses to the drug, and to give their reactions to a series of pictures of people. In addition, their voices were recorded and analyzed for emotional clues.

The results showed the LSD state to be a unique and puzzling one. Its primary characteristic consists of "very strong but opposing emotions occurring approximately at the same time" without any particular reason or outside stimulus, Dr. Katz noted. For example, one subject said "I feel jittery and nervous, but I also feel relaxed." Another reported "I feel serious but somehow everything seems funny and I feel like laughing."

Other reactions included:

- 1) A feeling of one's emotions and thoughts being out of control.
- 2) A feeling of detachment from the real world.
- 3) A feeling of perceptual sharpness at the same time the outer world seems unreal.
- 4) A perception of others as friendly but suspicious.

Dr. Katz found that subjects on the amphetamine felt they had increased control and improved motor reactions. Those on sugar pills showed little change from their normal moods. There were three main types of LSD reactions: One group felt moderately relaxed, happy, and peaceful; another, tense and jumpy; and the third, ambivalent, experiencing opposite feelings at the same time.

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But nearly all subjects at some time showed a confusing mixture of positive and negative feelings. Dr. Katz said: "They reported a number of feelings to be occurring at approximately the same time which would appear to the rational observer as opposed and contradictory. One of the most dominant aspects of the experience, then, was the contrariness and intensity of the basic effects which take place in the early stages of the LSD reaction."

Dr. Katz concluded that "this assemblage of competing emotions and perceptual counterparts and the general intensity of the reaction would appear to create a very bizarre experience for most individuals in our culture to undergo—and one which may not be easily assimilated or integrated into their previous experience."

The attempt to find meaning in such a paradoxical experience may help explain some of the philosophical concepts reported by users on higher doses of LSD, the investigators suggested.

The NIMH report, by Drs. Katz, Irene E. Waskow, and James Olsson, appears in the February 1968 issue of the *Journal of Abnormal Psychology*.

DATES AND EVENTS

- April 28-May 2 — Southern Psychiatric Association, Southern Pines, N. C.
- April 29-May 24 — Rehabilitative Nursing Workshop, Charlotte Rehabilitation Hospital, Charlotte, N. C.
- April 30-May 1st — N. C. Tuberculosis Association, Annual Meeting, Heart of Charlotte Motel, Charlotte, N. C.
- May 1-7 — Mental Health Week
- May 9-10 — Western Branch, N. C. Public Health Association, High Hampton Inn, Cashiers, N. C.
- May 13-17 — Biennial Convention: American Nurses' Association, Dallas, Texas
- May 15-17 — Meeting: 38th Annual Statewide Industrial Safety Conference, Jack Tar Hotel, Durham
- May 16 — N. C. Association of Industrial Nurses, Durham
- May 19-22 — Annual Meeting: National Tuberculosis Association, Houston, Texas
- May 27-31 — Annual Meeting: Southern Branch APHA, Roanoke, Va.



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Wilbur J. Cohen

President Johnson's choice for a new secretary of Health, Education and Welfare to replace Dr. John Gardner. (see story on page 3.)

Physicians' Attitudes Toward Venereal Disease Reporting

Is revealed in a recently conducted survey by the National Opinion Research. In summary the survey indicated that "there are not two kinds of physicians: those who faithfully report each venereal disease case they treat and those who consistently fail to report. Though there are some physicians in each of these categories, the majority exercise their professional judgment in each case and, on the basis of a multiplicity of factors, decide to report some patients and not to report others."

To Determine The True Extent of Venereal Disease

In this country, the American Social Health Association will on July 1 mail questionnaires to nearly 200,000 physicians and 13,000 osteopaths in private practice requesting them to report any venereal disease cases treated within the three-month period from April 1 to June 30. A similar survey conducted by ASHA six years ago revealed that private physicians were reporting about 11% of the infectious venereal diseases treated. The sponsoring organizations for the VD Incidence Survey are the American Medical Association, the National Medical Association, and the American Osteopathic Association, in cooperation with the U. S. Public Health Service. **State and local medical societies are urged to acquaint their membership of the current survey.**

Reported Cases of Gonorrhea

Continue to increase according to figures recently released by the U. S. Public Health Service. Gonorrhea increased by 13.7 per cent the first quarter of fiscal 1968 over the same period the previous year. And fiscal 1967 saw the second highest gonorrhea total in history!

Southern Branch APHA Meets in Roanoke, Virginia

"Elements of Total Family Health" will be one of the major addresses of the annual meeting of the American Public Health Association's Southern Branch May 28-31 in Roanoke, Virginia.

The speaker will be Dr. John J. Hanlon, President of the APHA. Dr. Hanlon is the health commissioner of Detroit. His address will be delivered May 30, at the second general session of the meeting. Sharing the platform will be Dr. Paul D. Sanders of Richmond, Virginia, editor of the Southern Planter, who will discuss "Social and Economic Impact of Family Health on the Community."

At the first general session, on May 29, Dr. Carl S. Winters, lecture staff consultant for General Motors Corporation, will deliver the keynote address, based on the meeting theme of "Family Health is Community Wealth."

Dr. Berwyn F. Mattison, APHA executive director, will tell the third general session "What's New in APHA and Affiliates."

The Southern Branch meeting is expected to draw members from 16 Southern states and the District of Columbia to the Hotel Roanoke.

Sectional meetings will be held on dental health, medical care, environmental health, nutrition, health education, public health nursing, personnel administration, and records and statistics.

Wilbur J. Cohen

Nominated as New Secretary for HEW

President Johnson's choice for a new secretary of Health, Education and Welfare to replace John Gardner has spent a third of a century building impressive credentials for the job.

Wilbur J. Cohen came to Washington in 1934 as a research assistant to the executive director of President Franklin D. Roosevelt's Cabinet Committee on Economic Security, which drafted the original Social Security Act. And since that time he has had a major hand in nearly every piece of important social and education legislation passed by Congress.

Mr. Cohen, 55, is an energetic liberal who has earned a reputation under three HEW secretaries — Abraham A. Ribicoff, Anthony J. Celebrezze and Mr. Gardner — as a master legislative technician. He has been serving as acting secretary since Mr. Gardner's resignation took effect March 1.

Except for a stint as a public welfare professor at the University of Michigan from 1956 to 1961, Mr. Cohen has devoted his career to continuous government service at HEW and its predecessor agencies. In January 1961 he was appointed by President John F. Kennedy as HEW assistant secretary for legislation. During his four-and-a-half years in that post, some 65 legislative proposals passed by Congress bore his imprint.

He was appointed HEW undersecretary by President Johnson on June 1, 1965, and served Mr. Gardner for two-

and-a-half years as coordinator of major policy issues between the legislative and executive branches. During that time, he was a leading strategist in the enactment of medicare legislation.

In many respects, Mr. Cohen has run the massive HEW agency — which employs 100,000 persons and has a budget second only to that of the Pentagon — during the tenure of the last three secretaries. As one observer put it, "Wilbur Cohen knows everything about HEW." He is recognized as a skilled administrator who, like former Defense Secretary Robert S. McNamara, has so thorough a knowledge of his subject that he can instantly produce facts and figures about programs that others run.

Mr. Cohen is also known as an official who drives himself because his responsibilities matter personally to him. In a magazine article last spring, Theodore H. White listed Mr. Cohen, along with John Gardner, McGeorge Bundy, James Conant and others, as one of the nation's leading "action intellectuals."

"After all his years in the capital," Mr. White wrote, "Cohen has lost none of his humanitarian glow — 'as though,' an acquaintance once said, 'he feels every person in the country who is home alone sick is his personal responsibility.'"

Though he has made his mark most deeply in the fields of health and welfare, Mr. Cohen's achievements in federal education legislation cannot be underrated. He sees a great need for the nation to extend federal education programs to help solve the poverty-welfare cycle. "Education is a main part of the welfare problem," he once told an interviewer. "It is the central solution. The vast majority of these people on welfare have no education; they're grade school and high school dropouts. We've got to educate these people, train them for jobs."

Natural Disaster Hospitals Being Located

Tornado and hurricane victims of the future may not have to go to a hospital—the hospital may go to them.

Boxed units of emergency medical supplies and equipment are being positioned by the Public Health Service in areas where natural disasters frequently occur. When a disaster strikes, the unit can be loaded on a truck, rushed to the scene, and used to aid the victims. The units are called Natural Disaster Hospitals (NDH).

The first NDH has just been placed at Enid, Oklahoma. "Enid's vulnerable location in the tornado belt makes it a prime site for an NDH," said Dr. Henry C. Huntley, Director of the Division of Health Mobilization which coordinates the disaster services of the Public Health Service.

In an agreement signed with DHM, the Garfield County (Oklahoma) Civil Defense Office has assumed responsibility for the storage and transportation of the unit.

Staffing of the unit will be handled by the Garfield County Medical Association.

The NDH is one phase of the Public Health Service's program to provide emergency medical supplies, equipment, and services quickly and efficiently in times of disaster. Packaged Disaster Hospitals (units of supplies and equipment necessary to establish a 200-bed hospital) and Hospital Reserve Disaster Inventories (30-day backup inventories of critical medical items for community hospitals) are phases already in operation. The NDH serves a need different from the other programs in that it is designed to operate as a short-

term medical facility for up to 24 hours.

In an emergency, the NDH can be quickly set up as a complete 50-bed unit. It can be used by a hospital to expand its facilities or it can be set up in a church, school or other available building to serve the emergency needs of approximately 300 casualties. The unit is small—83 cases of supplies and equipment; it is light-weight—2¾ tons; it is mobile—it can be transported in four station wagons or two pickup trucks. Its ability to go to the injured means that victims with slight injuries can be treated on the scene and released. Victims with grave injuries can be given essential treatment before being moved to permanent hospitals. If necessary, the NDH can provide surgery in the field.

The Public Health Service plans to position 24 additional NDH's in high-risk natural disaster areas this year. The first group will be placed in the middle west in anticipation of the tornado season. The second group will be placed in the hurricane-prone areas of the coastal regions before fall.

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Vol. 83

April, 1968

No. 4

Parents

of

Creative

Boys

Treat

Them

With

Respect

The parents of creative boys treat them like responsible adults; they regard their adolescent sons with respect and let them make their own decisions, according to the youngsters themselves.

These facts were reported by scientists of the National Institute of Mental Health, U.S. Public Health Service.

Dr. Lois-ellin Datta and Morris Parloff, Institute psychologists, asked 1,039 teen-age boys who had scored high in the Westinghouse Science Talent Search to describe how their parents had treated them from childhood to the present. The boys were divided into two groups—the more and the less creative—according to how the judges had rated the originality of their science projects.

The two groups of boys appeared to be similar in many ways. Slightly more than half had fathers who were employed in professional occupations, they did not differ in scientific aptitude, reported similar interest in becoming scientists and had equally high scores on the scholastic aptitude test.

However, the more creative students were more likely to come from the Northeastern States (44 versus 38 percent), from metropolitan areas (51 versus 41 percent), and from Jewish families (46 versus 38 percent).

In answer to NIMH questionnaires, both the creative young scientists and the controls said their parents were moderately affectionate, non-rejecting, and encouraged their intellectual independence.

But replies from the more creative boys shows that they had been given much more latitude and subjected to considerably less discipline than the less creative teen-agers. One boy said "They allowed me as much responsibility as they felt I could handle . . . I felt I was trusted." Another said "Rules, what rules? I was treated as a responsible adult." A third remarked, "I was simply allowed to make my own decisions."

In contrast, one of the less creative boys complained that "My father has a

set of rules that makes the penal code look like a picnic."

The study also showed that the more creative students considered their mothers as somewhat less rejecting and authoritarian than the less creative boys did.

However, relationships with fathers appeared to be more important to early scientific creativity in the boys than that with the mothers.

One creative boy suggested that his group may have represented fewer disciplinary problems than the average teenager, making the parent's task an easier one. He said "As I never had any desire to smoke, drink, stay out late, ride in a fast car, or do any other undesirable things, my mother never found it necessary to condemn my avocations and habits."

However, Dr. Datta emphasized that the parents did not appear to practice a disinterested hands-off policy. She explained that the more creative boy was "more likely to perceive both parents as providing a 'no-rules' situation in which his integrity and responsibility were assumed rather than one in which expectations were enforced by authoritarian control and punishment. The results suggest that creative behavior may be significantly related to expectations communicated in ways that the child sees as trust in his ability to choose rationally, thus enhancing his ability and desire to achieve by independence."

Dr. Datta noted that 41 percent of the more creative boys but only 26 percent of the less creative ones later enrolled in six top colleges—M.I.T., Harvard, Princeton, Yale, Columbia University, and California Institute of Technology.

The report by Drs. Datta and Parloff appears in the Proceedings of the 75th Annual Convention of the American Psychological Association.

Cities Chosen

for Narcotic

Addict Aftercare

Three cities have been selected as the first sites of Federal aftercare contract negotiating offices for narcotic addicts. The cities are Los Angeles, Chicago, and New York.

These metropolitan area offices are the first of a proposed national network which will arrange for the treatment of narcotic addicts discharged from the inpatient units of the NIMH Clinical Research Centers at Fort Worth, Texas and Lexington, Kentucky.

NIMH officials said these cities were selected because of their large addict populations. Additional cities will soon be added to complete the network.

The purpose of the program is to reduce the high relapse rate of patients who have been treated for narcotic drug addiction.

Meeting Stresses Better Health Care for Migrants

Providing better health services to migratory agricultural workers is the concern of over 200 persons who attended the Eastern States Migrant Health Conference in Orlando, Florida. Sponsored by the U.S. Public Health Service, the meeting focused on the problem of making health care available to the 80,000 migrants who harvest crops along the Eastern Seaboard.

Participants from eleven States included representatives of national, State and local governments, voluntary organizations, migrant health projects and growers' associations.

A "Cold" That Wasn't A "Cold"

And then there was the 39-year-old waitress who complained for six months about her "cold."

She had a low-grade fever almost every day. She suffered from chills, lack of sleep, and irritability. After losing 20 pounds, she weighed 107 when admitted to a Philadelphia hospital.

Her trouble? Too much coffee-drinking.

She drank 15 to 18 cups a day, the woman told her physician. Her cold symptoms disappeared after five days in a hospital, during which she was limited to one cup of coffee a day.

A report on this case of caffeinism appears in a recent (Dec. 18) *Journal of the American Medical Association*. The author is Hobart A. Reimann, M.D., of Hahnemann Medical College and Hospital, Philadelphia.

Several common household items can cause illness if used excessively, Dr. Reimann points out, and the illness can be mistaken for other disease.

Coffee, tea, dentifrices, and even peanuts contain chemicals called xanthine alkaloids and can induce illness sometimes mistaken for other disease, he said.

A cup of coffee contains about one-tenth gram of caffeine. A single one-gram dose of caffeine causes mental confusion, shivering, tremor, vomit-

ing, and diarrhea. Ten grams of caffeine is said to be fatal.

The waitress's caffeine intake was probably more than 1½ grams a day. The intake was spread over several hours, however—probably the reason she was not more seriously ill.

The woman also smoked more than a pack of cigarettes a day, and regularly took sleeping pills. The nicotine and drugs also may have affected her reactions to caffeine, Dr. Reimann said.

A main point of his report is that great effort can be wasted on testing for diseases which a patient does not have, but whose symptoms are similar to those caused by excessive use of caffeine and other stimulants. In the waitress's case, Dr. Reimann happened to note that her fever rose after that daily cup of hospital coffee, but declined later. It was then that further questioning disclosed how much coffee she drank.

"The cause (of illness) is easily overlooked unless a patient's habits are discovered," Dr. Reimann said. "Prompt recognition (eliminates the need for) much clinical effort, laboratory testing, unnecessary therapy, and expense."

Reactions to caffeine are influenced by a person's age, emotional or nervous state, "or by the idiosyncrasies of people," Dr. Reimann said. Its effect is widely variable, often opposite in different people or even in the same person at different times.

"Caffeinism is said to be current among intellectual workers, actresses, waitresses, nocturnal employees, and long-distance automobile drivers," Dr. Reimann said. "Illness otherwise unexplained may be caused by excessive intake of the xanthine alkaloids (caffeine), including those in coffee, tea, cocoa, and those in other popular beverages."

"Removal of the cause is the cure," he said.

Franklin Institute Offers Sculpture Award for Best Original Achievement in Control of Environmental Pollution

Created by J. Daatselaar under a commission from the Dollinger Corporation of Rochester, New York, this sculptured work signifies the newly established Lewis L. Dollinger Pure Environment Award. According to the artist, "The burnished aluminum in its simplicity of geometric shape symbolizes modern day industrial technology. The ceramic representation of the human embryo within the industrial society suggests purity and life support.

"The boldness of industrial strength," Mr. Daatselaar points out, "surrounds and supports all of contemporary life. Thus, the motion of the sculpture is generated by this contrast of strength with huddled dependence, giving way to man's realization that his natural environment must be protected if his future life is to be maintained."

The world's scientific, industrial and academic communities will be scanned for the "best-judged original contribution, available in print or otherwise, reflecting significant achievement in the recognition, detection and abatement or control of environmental pollution." The recipient of the sculpture Award, who will also receive a cash honorarium of \$2,500, will be selected by the Committee on Science and the Arts of The Franklin Institute, Philadelphia, Pennsylvania, America's oldest science institute.

See opposite page

Lewis L. Dollinger Pure Environment Award 1968

Awarded by Franklin Institute



Whooping Cough in Teenagers and Adults is Disabling Illness

Whooping Cough in teenagers and adults is a disabling illness characterized by a severe persistent paroxysmal cough occasionally culminating in vomiting. This often lasts for weeks or months. The illness exists in mild forms and is often simply called bronchitis.

A public health laboratory in Michigan is carefully culturing and studying persons with whooping cough. In 1967, 1,060 cases occurred in Michigan. A study of persons exposed to whooping cough reveals that 21% of persons who were vaccinated 0-3 years previously develop whooping cough. The corresponding attack rate for persons vaccinated 4-7 years previously is 47%, for 8-11 years previously is 65%, and for 12 or more years previously is 95%. Studies in Michigan reveal that 55% of positive pertussis cultures come from the 10-19 year old age group. Twenty percent come from persons 20 years old or older.

Analysis of the serotypes which have been isolated suggests that infection with organisms devoid of number 2 antigen are becoming more frequent. It seems likely that the antigenic components of the pertussis vaccine may one day have to be altered.

Although pertussis is now a disease of teenagers and adults (in immunized communities), it is not clear whether teenagers should receive another "booster" vaccination. The neurologic sequelae after vaccination, though rare, may be more frequent in adults.

The North Carolina Supreme Court

According to a UPI report has declared unconstitutional a Charlotte ordinance designed to outlaw massages by members of the opposite sex. The 1966 ordinance was passed at the request of police who complained of "lewd massages" and prostitution in the city's massage parlors. The ordinance exempted the YMCA, the YWCA and barber and beauty shops. Supreme Court Justice Susie Sharp, writing for the majority, said the exemptions made the ordinance discriminatory.

Motorcycle Riders Beware

Motorcycle riders are sometimes killed or injured because automobile drivers or pedestrians refuse to share the road with them.

The above statement can be found in a new, revised edition of the pamphlet, "Motorcycles in the United States." The pamphlet is published by the injury Control Program of the Public Health Service's National Center for Urban and Industrial Health in Cincinnati.

Other causes of motorcyclist injuries and deaths, according to Dr. Richard E. Mariand, Chief of the Center's Injury Control Program, are: (1) many new riders lack adequate training and experience in controlling their vehicles, and (2) many riders have not been sufficiently informed of the dangers of riding motorcycles and are unprepared to deal with hazardous situations.

The new pamphlet includes information on motorcycle registrations, the importance of wearing helmets and other protective clothing, as well as benefits of wearing reflective materials for night visibility.

A Strange Alliance—

A Soap Bubble

An 1827 French

Physicist

A Modern Computer

What do a soap bubble, a French physicist who died in 1827, and a computer have to do with modern open-heart surgery? At the University of North Carolina School of Medicine, William Hood, M.D., Charles Rackley, M.D., and Ellis Rolett, M.D., with the help of North Carolina Heart Association Heart Fund dollars are putting these three seemingly unrelated pieces together to add significantly to our knowledge of how the heart works.

In the early 1800s, Pierre Simon de LaPlace formulated a law of physics which can be used to calculate the surface tension of a soap bubble. Its principle guides engineers today in the design of containers which hold compressed gas. The law of LaPlace relates the tension on the wall of a chamber to the size and shape of the cavity, the pressure within the cavity, and the thickness of the wall.

About five years ago, a group of investigators in Seattle devised a special X-ray method of measuring the dimensions of the left ventricle of the heart, as well as the thickness of the heart wall. (The left ventricle is like an egg in shape and is the main pumping chamber of the heart.) This advanced X-ray technique provided two of the three factors needed to apply LaPlace's law of physics to the human heart. Through a procedure known as cardiac catheterization, the pressure within the heart is measured, provid-

ing the third factor in LaPlace's law.

But the question was not answered as to whether this law of physics could be put to practical use in terms of the human heart. Dr. Hood and his associates have been investigating LaPlace's law of physics and its relationship to heart patients. Evidence to date seems to support the fact that LaPlace's law does have clinical usefulness. The UNC researchers have found that in response to valve obstruction or leakage the left ventricular wall normally thickens "appropriately" so that tension tending to rupture the wall is minimized. If the wall does not thicken "appropriately," it usually means the heart muscle is weak and the pumping ability of the heart is impaired.

What does this mean to those individuals who may need to undergo surgery to replace a valve damaged through disease? If the heart muscle of such patients is weak, they may not improve even though their valvular difficulty is completely corrected. By evaluating the appropriateness of the left ventricular wall thickness, Dr. Hood and his associates hope to be able to predict which patients have good enough pumping action to benefit from surgery.

The necessary calculations have been greatly facilitated by the use of computer programs specially developed in UNC's Division of Bioengineering.

Dr. Hood, in a paper presented recently to the American College of Cardiology, won first prize among 53 presentations for his report detailing the nature of this research. A gold medal and a check for \$1,000 accompanied this recognition.

And so a strange alliance between a soap bubble, a long-deceased physicist, and a 20th century computer may yet add another positive tool in the continued fight to add years of life to those afflicted with heart disease.

Research to Identify "High-Risk" Suicide Group

Research to identify the "high-risk" suicide group in New Hampshire will be supported by a \$29,752 Federal grant to the New Hampshire Department of Health and Welfare, it was announced by Dr. Stanley F. Yolles, Director of the National Institute of Mental Health, U. S. Public Health Service.

All suicides in the State in the past 10 years will be studied in an attempt to clarify the characteristics of the high-risk suicidal individual in a rural State. Age, sex, race, marital status, occupation, socioeconomic status, physical and mental health, place of residence at time of death, mode of death, and religion will be among the factors studied.

"Psychological autopsies," detailed studies of the circumstances surrounding a suicide, will be conducted for all suicides in New Hampshire during the two years of the project.

All findings will be computerized for easy collation.

The investigators hope that exhaustive study of past suicides will enable the designing of suicide intervention services specially tailored to lower the suicide rate in rural areas.

In 1964, New Hampshire ranked seventh in the United States with respect to suicide. There were about 14.8 suicides per 100,000 population or 89 statewide in 1964.

During 1967 North Carolina had a total of 472 suicides.

Poison Ivy, Oak and Sumac

The leaves of poison ivy, oak, and sumac usually share the blame for causing an allergic rash and blisters which afflict millions of Americans during warm weather. Actually, the culprit is urushiol—an ingredient found in the sap of all three plants—according to a new folder prepared by the National Institute of Allergy and Infectious Diseases (NIAID).

Urushiol is a potent substance affecting 7 of every 10 persons it touches. It causes an allergic contact dermatitis of a severity which varies with individual sensitivity and amount of exposure. As with all allergies, it is not known why some people react to urushiol while others do not.

Contact with urushiol is necessary to develop an allergic reaction. Touching a plant is the usual method of exposure. But garden tools, work clothes, roving pets, or the smoke from burning plants can provide indirect contact with the substance.

Most people worry about scarring—which rarely occurs—and overtreat the symptoms. Removing all urushiol from the skin and eliminating indirect contact are most important procedures. A drying lotion usually relieves the rash and its accompanying itch, although a particularly susceptible person with a severe reaction should, of course, seek a physician's care.

The new folder also devotes a section to pointers on how to recognize, avoid, and eliminate the plants.

Single copies of "Poison Ivy, Oak, and Sumac" Public Health Service publication No. 1723, may be obtained from the Information Office, National Institute of Allergy and Infectious Diseases, Bethesda, Md. 20014.

Jogging Is On The Way To Becoming A National Sport

Hal Higdon writing in the Magazine Section of the New York Times stated that "Jogging is an In Sport." The North Carolina Heart Association goes one step further and suggests that jogging may become the national sport.

Ever increasing evidence is being amassed to indicate that the sedentary life being led by many Americans may well be contributing to the incident of

heart disease in this country. Dr. Paul Dudley White, one of the founders of the American Heart Association, has long advocated exercise as a preventive measure in heart disease. Other noted Americans have taken up the cause. Secretary of the Interior, Stewart L. Udall, along with Senators Strom Thurmond and William Proxmire are among our government officials who are devoted advocates of jogging.

Jogging differs from walking or running in that with jogging there is more up and down movement than any mode of locomotion. This up and down movement of the arms and legs adds to the overall effect in that it stimulates the circulation of the jogger.

Hal Higdon in his New York Times article states that "when an out-of-shape person starts to jog, he may find it difficult to maintain even a slow 6 mile per hour pace for more than a hundred yards." While the North Carolina Heart Association agrees that jogging is an excellent form of exercise, it hastens to add that no one should attempt to take up jogging until they have had a physical examination. This is especially important with those individuals who are overweight or have a history of heart disease.

Jogging may well become the "In Sport" that can add years of healthy, happy existence to many who would otherwise find it very difficult to engage in any physical activity. One of the especially appealing aspects of jogging as a sport is that all one needs is a good pair of shoes, an old pair of trousers, a shirt, and if nothing else, a large room to get into the swing. There is no expensive equipment to buy, no clubs to join, and it's a sport that one can enjoy in public or in private, day or night. The North Carolina Heart Association urges everyone to see their physician and based on his recommendation join the "In Sport."

Education to Play a Key Prevention Role

A Sharp Increase In The Detected Use of Marijuana

By U.S. troops in Vietnam was disclosed recently as the Defense Department took steps to unify anti-drug policies in the armed forces, according to a recent UPI story. Frank Bartimo, assistant Defense Department counsel was quoted as saying that final figures for 1967 will show a rate of 2.5 men per thousand troops compared with a rate of just under one man per thousand in 1966. Whether the figures reflect an actual increase in the use of marijuana or better enforcement because of publicity is an open question. A Department of Defense directive has been issued to "prevent and eliminate drug abuse in the armed forces." Education will play a key role in the prevention program.

An American Medical Association Committee

Has concluded that marijuana is a dangerous drug, but current legal penalties for possessing it are too strong, according to an AP dispatch. Dr. Henry Brill, chairman of the AMA committee on Alcoholism and Drug Dependence and vice chairman of the Narcotics Control Commission of New York, said marijuana has a "long and clearcut history as a drug of abuse in Asia and the Near East where it is recognized as a serious social problem associated with psychiatric disorders."

THE EPIDEMIOLOGY OF TETANUS

The master of a large ship mashed the index finger of his right hand with the anchor. Seven days later a somewhat foul discharge appeared; then trouble with his tongue—he complained he could not speak properly. The presence of tetanus was diagnosed, his jaws became pressed together, his teeth were locked, then symptoms appeared in his neck. On the third day opisthotonos appeared with sweating. Six days after the diagnosis was made he died.

Hippocrates 460-375 B.C.

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Health Planning Council Gets Under Way

The recently formed Central Coastal Plains Health Planning Council has wasted no time in beginning to fulfill the purposes for which it was created. This group of professional health service personnel, health service consumers, community leaders and interested private citizens from Wilson and Greene Counties have as their main objectives, determination of health services necessary to and desirable for those persons living in the planning area and discovery of methods for providing these services.

Dr. Badie T. Clark is Chairman of the Central Coastal Plain Health Planning Council.

One of the first needs determined by the Council was the necessity of upgrading the quality of health services already existing in the planning area. Toward the accomplishment of this goal, this Council is sponsoring its first Symposium at 1:30 P.M. on May 22, 1968 at the Imperial Inn in Wilson. Dr. Thomas Griffin of Wilson listed the goals of the Symposium as:

1. Develop a connecting link for free interchange between insti-

tutions concerned with patient care and those primarily concerned with research and teaching.

2. Provide methods for extending and coordinating the N. C. Regional Medical Program objectives to community hospitals by use of a communication network.
3. Develop frequent interchange between those practicing in the field and those concerned with research and teaching.
4. By leadership and example, encourage community hospitals to become learning centers for all health care personnel.
5. Stimulate highly motivated and capable practitioners in health care to become interested and actively involved in teaching and learning.

Dr. James Lieberman will address the group concerning the success of a two-way microwave television system presently in use in the Atlanta area in both diagnostic consultation and continuing health and medical education. It will be pointed out in his discussion the tremendous possibilities offered by this medium because of its immediacy, visual presentation, and emotional impact.

In addition to Dr. Lieberman and Dr. E. T. Beddingfield, First Vice-President of the Medical Society of the State of North Carolina, several other distinguished health service specialists are scheduled for the Symposium. Participation of the out-of-state speakers will be supported by a grant in aid to the Central Coastal Plains Health Planning Council from Merck Sharpe & Dohme.

The Symposium will end following a 6:00 P.M. dinner meeting and summary of findings presented by Dr. E. Harvey Estes, Chairman of the Department of Community Health Sciences, Duke Medical Center, Durham, North Carolina.

THE HEALTH BULLETIN

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1968

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DATES AND EVENTS

May 19-20 — American Social Health Association, Board Meeting, Shamrock Hotel, Houston, Texas.

May 19-22 — Annual Meeting: National Tuberculosis Association, Houston, Texas.

May 20-22 — Child Welfare League Regional Conference, New Orleans, La.

May 21 — Council on Aging, 112 W. Lane St., Raleigh, N. C.

May 23-25 — S. C. Public Health Association, Myrtle Beach, S. C.

May 27-29 — Planning Computer-Based Hospital Information Systems, New York Hilton Hotel, New York.

May 27-31 — Annual Meeting: Southern Branch, APHA, Roanoke, Virginia.

May 29-30 — N. C. Heart Association, 19th Annual Meeting & Scientific Sessions, Winston-Salem, N. C.

May 30-31 — Meeting of the Southwestern Medical Society, Roaring Gap, N. C.

June 6 — Regional Rural Health Conference, Assembly Building, Wilson, North Carolina.

June 6-7 — Eastern NCPHA, John Yancey Hotel, Atlantic Beach, N. C.

Three cases of poliomyelitis recently occurred in Texas. All cases were in previously unimmunized children less than two years of age. While there have been no very recent cases of poliomyelitis in North Carolina, it should be recalled that a case of paralytic poliomyelitis did occur in North Carolina in 1967. Previous to this no case of this disease, which is both potentially fatal and a potential embarrassment to our child care programs, had occurred in this state for more than two years.

Scientists of the Public Health Service's National Center for Air Pollution Control have developed a device which measures the density of smoke emissions from diesel-powered vehicles by simulating the responses of the human eye.

The proposed new Federal standards to control automotive air pollution—include a requirement that smoke from diesel engines be limited. The newly developed device, called the light extinction meter, is designed primarily for use in laboratory test procedures to determine whether this requirement is being met.



THE HEALTH BULLETIN

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20th Anniversary of The Arthritis Foundation Recognized

Mrs. Dan K. Moore gave recognition to the twentieth anniversary of The Arthritis Foundation at the Executive Mansion in May. The First Lady's guest of honor was little Miss Ann Elizabeth Emery of Charlotte who is Child of Hope for 1968. Among the three hundred guests were representatives of the military services. Shown above (left to right) are Mrs. Maurice J. Vorwald, Specialist-5 Maurice J. Vorwald, Ann, the First Lady, Major George Marecek and Mrs. Marecek. Major Marecek and Specialist Vorwald are members of the United States Army Special Forces — the Green Berets — at Fort Bragg. May was Arthritis Month in North Carolina by Proclamation of Governor Dan K. Moore. Mrs. Moore is Honorary Chairman of the North Carolina Chapter of The Arthritis Foundation.



Dr. Richard Page Hudson, Jr. Named Chief Medical Examiner for North Carolina

Richard Page Hudson, Jr., M.D., has been named Chief Medical Examiner for the State of North Carolina, according to announcement by Dr. Jacob Koomen, State Health Director. This appointment was approved by the State Board of Health in their recent annual meeting in Pinehurst.

The Office of Chief Medical Examiner, to function under the auspices of the State Board of Health, was created in an Act by the 1967 General Assembly to provide for a statewide system for post-mortem medicolegal examinations. The appointment is made for a term of four years.

In announcing the appointment Dr. Koomen said, "We are most fortunate in securing the services of Dr. Hudson, who has outstanding qualifications for the position of Chief Medical Examiner. His leadership should mean much to North Carolina in this important field."

Dr. Hudson, a native of Richmond, Virginia, is a highly qualified and skilled Forensic Pathologist. He will assume his new duties September 1st at an annual salary of \$30,000. The office of the State Medical Examiner will be located in Chapel Hill and will function in close collaboration with the University of North Carolina, School of Medicine, Department of Pathology.

Dr. Hudson attended Duke University, Durham, N. C. and the University of Richmond, Richmond, Va., where he received a B.A. degree in Chemistry. He received his medical degree from the Medical College of Virginia. He served his Internship in Pathology at John Hopkins Hospital and was Assistant Pathologist at John Hopkins Hospital from July, 1957 to June, 1958, when he was called to military duty as a Captain with the U. S. Air Force Medical Corps.

He was a Research Fellow at Harvard Medical School, Department of Legal Medicine and was a resident in Clinical Pathology at Kings County Hospital, New York. He has served as an Instructor in Pathology at John Hopkins University, State University of New York, Downstate, and the Medical College of Virginia. Currently, he is Associate Professor in Surgical Pathology at the Medical College of Virginia.

Dr. Hudson holds certification in Anatomical and Forensic Pathology. He is licensed to practice medicine in Virginia, New York, California and Massachusetts.

He is a member of the Richmond Academy of Medicine; Medical Society of Virginia; American Medical Association; Fellow, College of American Pathologist; American Academy of Forensic Sciences; Fellow, American Society of Clinical Pathologists; and Japanese-American Society of Pathologists.

Dr. Hudson is married to the former Sally Sewell. They have four children.

Dr. Charles M. Cameron, Jr. Resigns to Accept Oklahoma Position

Dr. Jacob Koomen to Supervise Work Temporarily

Governor Moore has announced that Dr. Charles M. Cameron, Jr., is resigning as Director of the State Office of Comprehensive Health Planning in the Department of Administration. Dr. Jacob Koomen, State Health Director, temporarily will supervise operations of the Office of Comprehensive Health Planning.

Dr. Cameron, on loan from the University of North Carolina School of Public Health during the past year, is leaving North Carolina to assume, effective July 1st, the position of Professor and Chairman of the Department of Health Administration in the newly-created School of Health at the University of Oklahoma Medical Center in Oklahoma City. He also will serve as Health Planning Consultant to the Oklahoma Health Planning Office and to the Oklahoma Department of Public Health.

Dr. Koomen will retain his appointment as State Director of Public Health and Secretary to the State Board of Health.

"In view of the expanding role of the Office of Comprehensive Health Planning, both in the coordination of State and private health activities in North Carolina and in Federal-State relations in the health field, the further development of an active, effective health planning program is in the best interest of all the health services in the State," Governor Moore said.

"The Health Planning Office, recognized nationally as one of the best in the country, is playing a major role in the State program for the maximum development and use of all our resources pertaining to health," the Governor added. "We have been fortunate in having a man of Dr. Cameron's experience and capability to guide the office during its first difficult year. We also are very fortunate in having a man of Dr. Koomen's insight and ability to continue this work for the next several months."

Dr. Cameron, a native of Tennessee, has been active in public health in North Carolina since 1953 serving initially as an epidemiologist for the North Carolina State Board of Health and later as the first director of the Board's demonstration program in Home Accident Prevention. He joined the faculty of the Department of Public Health Administration in the University of North Carolina School of Public Health in 1955 and at present, holds the rank of full professor. During the 1966-67 academic year, he completed a study for the U. S. Public Health Service dealing with trends and developments in health planning in the United States.

He has served as consultant to many health organizations in North Carolina and in the Southeast and has directed studies dealing with health manpower, community health services, and with planning to meet the State's major needs in the field of health. He is President-elect of the North Carolina Public Health Association.

With approval of the Governor, Dr. Koomen was named by the State Board of Health as State Health Director in May of 1966, and has been active with the State's comprehensive health planning program since its inception, serving both on the Technical Committee and on the Governor's Advisory Council on Comprehensive Health Planning.

Health Careers

Recruitment

to Become

Major Education

Effort

North Carolina Blue Cross and Blue Shield, Inc. has announced a major education effort in behalf of health careers recruitment; distribution of a book entitled "The Hospital People" to persons interested in pursuing hospital careers.

H. C. Cranford, Jr. Director of Public Relations, said distribution of the book is part of a continuing effort by North Carolina Blue Cross and Blue Shield, Inc. to help the hospitals of North Carolina meet their critical need for nurses, technicians and other personnel.

"In recent years public attention has focused on the technological advances hospitals have made in patient care," Cranford said, "but frequently overlooked are the human hands which operate the new machines and the human minds which evaluate new techniques.

"More than 200 job classifications are within a hospital's walls. While personnel filling these job classifications vary in background, education and skills, they have a common goal—better patient care—and a firm belief that a hospital is 'people caring for people'."

Supporting the idea that technology is useless without technologists, the Blue Cross book, "The Hospital People," recognizes these individuals and their coworkers who stand ready not only in time of illness, emergency or disaster, but who serve the community in other hospital related ways:

1. Conducting educational programs to keep professional and supervisory staff informed of latest scientific advances and techniques.
2. Conducting programs to educate the general public in aspects of health care.
3. Cooperating with agencies to carry out screening programs to detect early symptoms of disease.

"The Hospital People" has been widely utilized in health careers education and recruitment programs and as a tool in helping to explain the rising costs of hospital care. The book graphically illustrates the vast amount of special equipment, highly skilled health care team members and expanded facilities which are needed to provide optimum health care for all the people.

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NARCOTICS

by

Alvin Shuster

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LONDON — "The real question," the doctor said after prescribing heroin for a young commercial artist, "is whether we are about to develop in this country an American-type black market in narcotics."

The doctor was speaking from a desk in a narcotics clinic in central London

that is representative of the "treatment centers" the Government hopes to have in sufficient numbers in the spring when a major change takes place in the "British system" of handling addicts.

The Government has come to the conclusion that its old methods of handling the heroin addict have failed. The philosophy remains the same—a drug addict is a sick person and not a criminal and should receive the drugs he needs legally so he can continue living as near normal a life as possible.

But the way the British will dispense the drugs will change in the spring. General practitioners will no longer be permitted to prescribe heroin for an addict. He will have to refer all comers to one of the new "treatment centers" to be set up under the psychiatric departments of hospitals.

The major reason for the change is that a few doctors were prescribing too much heroin for their addict patients, giving them a surplus either to sell to others reluctant to go to the doctor or to try to "push" on the non-addicted.

The young artist, sitting in the waiting room of the clinic, put it this way:

"I used to go to a private doctor. He charged me 2 pounds (\$4.80 a week) and gave me all I needed. But I decided to come here where everything was free—the doctor and the heroin.

"But some of my friends made their living from this other doctor I knew. They could get more than enough from him. Then they would sell it. They were able to sell so much they could afford another visit to the doctor, pay their rent, buy their food, and live it up in the West End night clubs."

The surplus was reasonably priced, undercutting any heroin that might be brought into Britain illicitly. The result is that the international traffic in heroin has remained virtually clear of these shores.

Even those receiving free heroin have occasionally turned to the "black market."

"I bought a couple," one young man openly admitted to the clinic doctor last week. "You haven't given me enough. It cost me a pound a grain."

The real fear here is that the new system may well break down under a flood of heroin addicts. No one really knows how many there are in this country, and the Ministry of Health may not have the facilities to handle them all when they are channeled to the treatment centers.

The doctors there will be careful in what they prescribe, and the "surplus" market will be sharply reduced. This could leave the field open for the illicit international dealers. For other addicts may prefer to remain away from the "treatment centers" and buy from illegal sources as long as their money holds out.

"The addicts are essentially shy people," a doctor said. "They may not like change. They may regard the centers as something like a probation officer. They may not like having their name sent to the Home Office, a system that goes into effect at the end of this month. The hospital center may just seem too much like government to make them feel comfortable. The illicit market could come."

The theory behind the treatment centers is that under the guidance of specially trained doctors the addicts may be persuaded slowly to give up their heroin addiction.

"The goal is to switch them from heroin to methadone (a narcotic without the withdrawal symptoms of heroin) to nothing," the doctor in the clinic said. But of course that seldom works. We have had some success in switching them from heroin to the stimulant methadrine."

The Government also hopes to be able to persuade more addicts to accept hospitalization, but there is a serious question whether the hospital system will be able to handle any large numbers. For example, as of early this year, only 42 heroin addicts were being treated as in-patients in the London area. How much more space will be available for such patients remains to be seen.

Another change will be in the prescription themselves. Heretofore, a general practitioner merely gave an addict a prescription for a week's supply. He picked up all the heroin at the same time and was free to sell some.

Now the doctor will prescribe a week's supply of the free heroin, but he will mail it direct to the addict's pharmacist. This will prevent the addict from attempting to alter the form to obtain more heroin and enable the pharmacist to control the flow of it by dispersing it daily. It is unlikely an addict will sell his daily supply.

Officials of the Ministry of Health have come to no firm conclusion as to why Britain has experienced its rise in addiction. They say only that it is part of the "social phenomenon" being experienced in other countries, as expressed particularly in a "rebellion by youth." Most of the addicted in this country fall within the youthful category.

Many experts here believe that Britain will have to come one day to compulsory hospitalization. But for the time being the Ministry of Health wants to try its new system.

"I like this place," said an addict last week after getting his sterile hypodermic needles from a pretty nurse. "I like the doctor and the nurse. But I've got junkie friends who just wouldn't come to a place like this."

That is why the British doctors are worried.



Staff of the North Carolina Hospital Association. Seated, left to right: Mrs. Ann Flake, secretary to assistant executive director; John H. Ketner, assistant executive director; John P. Marston, program coordinator for health careers. Standing, left to right: Mrs. Ellen Walters, staff assistant; Marion Foster, executive director; Mrs. Brenda Johnson, secretary to executive director.

Your North Carolina Hospital Association

The North Carolina Hospital Association shall be a voluntary non-profit organization, the purpose of which shall be to promote the development, improvement, and perpetuation of hospitals and related health services for the people of North Carolina.

—from NCHA Bylaws

Fulfilling the challenging goal are six people in the Association office located on Oberlin Road in Raleigh.

Marion J. Foster, executive director,

has been with the Association since 1956. The advent of Federal programs such as Medicare has increased the complexity of the hospital administrators' responsibility, and the Association, through Mr. Foster's law background and experience, has provided invaluable guidance in this area.

Prior to joining the Association Mr. Foster was staff attorney for the AHA in Chicago, and he has served as legislative assistant for the Washington Service Bureau of the AHA.

Mrs. Brenda Johnson, Mr. Foster's secretary, relieves him of many routine duties by answering requests or supply-

ing material needed by hospitals and other agencies. Five years of active involvement in various functions of the Association qualify Brenda as a main-spring of the Association.

John R. Ketner, assistant executive director, joined the Association April 1, 1965.

Having served as business manager and assistant administrator of Cabarrus Hospital in Concord, Mr. Ketner brings to the Association many years of experience in hospital administration and accounting.

He is currently treasurer of the North Carolina Health Council and holds membership status with the American College of Hospital Administrators. He is also a Fellow of the American Association of Hospital Accountants.

A new staff member is John P. Marston who became Program Coordinator for Health Careers in April. Within the next few weeks he will name new co-workers for this program which seeks to attract qualified young people to health careers.

Experienced in mass communication and journalism, Mr. Marston was director of communications and public affairs with the North Carolina Board of Science and Technology before he joined the Association staff.

He has also served as assistant director of the News Bureau with the University of North Carolina at Greensboro.

The office receptionist is Mrs. Ann Flake who also keeps the Association's books, answers correspondence for Mr. Ketner and can supply many answers for interested inquirers.

Mrs. Ellen Walters, staff assistant, is currently working on a 50-year history of the Association. Her duties are varied, and her position is new, so her role will be an expanding one.

These are your Hospital Association people, and like the "Hospital People," they are people helping people.

"Drownproofing" — Water Survival

The Public Health Service again announces the availability of a wallet card describing a water survival technique called "Drownproofing." This technique with proper instruction can readily be learned by adults and children.

Entitled "Safety Tips In - On - And Around the Water," the card is being distributed by the Service's Injury Control Program of the National Center for Urban and Industrial Health in Cincinnati.

"Drownproofing," said Dr. Richard E. Marland, Chief of the Center's Injury Control Program, "uses simple aquatic skills to keep a person afloat—even in rough water—for a long period with a minimum expenditure of effort and energy.

"The technique enables a person to take advantage of his best floating position so that, with simple movements of the arms and legs, he can breathe in an up-and-down bobbing action.

"Drownproofing is not a skill that a non-swimmer can perform successfully without instruction from someone trained in lifesaving and swimming techniques. Parents particularly are urged to seek this instruction for themselves and their children at their local pool, swim club or swimming organization."

The drownproofing technique was developed by the late Fred R. Lanoue, former professor of physical education and head swimming coach at Georgia Institute of Technology. The card also features other safety tips which were prepared in cooperation with American National Red Cross. The card may be obtained free in quantities of up to 100 by writing Public Inquiries, National Center for Urban and Industrial Health, 222 East Central Parkway, Cincinnati, Ohio 45202.

Glue-Sniffing

By JIM CHESNUTT
Times Staff Writer

"Feelthy peectures, meester?" And from under the counter they come. That you understand.

But glue?

From under the counter yet?

That is exactly the state of the glue business in several sections of Raleigh now. Notably, dime and variety stores located near the high and junior high schools are finding it necessary to place some kind of curtailment on purchasing glue. The glue, authorities are finding, is being used as a stimulant in increasing numbers by Raleigh students.

Cary Allen, manager of the Person Street Variety Store, said, "I've not had as much call for the glue since I put restrictions on buying it." The glue, in Allen's store, has been placed "under the counter" and is limited to two tubes per purchaser. Allen recently had to turn in three girls for shoplifting 22 tubes.

Two of the girls have subsequently left Enloe, where they were in school, one leaving for extenuating acts (truancy) and the other dropping out.

"The girl that left (truancy) told me her 17-year-old friend was really hooked," Mrs. Phyllis Wren, probation officer counselor said. "She also told me she knew at least 15 other kids sniffing glue during the lunch hour."

"Everybody's Doing It"

Gary Clark, principal of Enloe, said, "We have yet to find anybody sniffing glue on this campus. I've never suspended a student for sniffing glue; she did it away from school, anyway."

Clark observed it was usual for a student to use the "but everybody's doing it" approach to a problem. "We realize it can become serious, and we'll do everything to stop it. But at present, it's a small group participation.

Both assistant principal, Bill Johnson, and Judy Barrett, woman's guidance counselor, agreed the problem at Enloe was, at present, largely non-existent said Johnson. "The only connection at Enloe has been school drop-outs completely outside our jurisdiction."

Mrs. Wren first started noticing the rising incidents of glue-sniffing in the early spring—around February. "To catch a person is extremely hard," she said. "We had a couple of boys caught running from the police. It turned out they were on glue—they appeared drunk, with bulging eyes. Glue affects students much like alcohol; it gives them a false courage."

"But they don't realize — and their parents don't realize — the extreme danger of messing with this stuff," Mrs. Wren said. "It damages the brain, lungs and the liver. I've got a girl at Oakberry School for the mentally retarded now because of glue-sniffing."

"Friends Sneak Glue"

Glue-sniffers seem to come from the middle to the upper middle classes in the Raleigh School system. "Just last week, one of my girls in a detention home had friends try to sneak glue to her," Mrs. Wren said, bringing an old paper bag from her desk. "The nurse noticed the girls acting strangely and searched the room. She found this under the mattress."

The bag had been spread with glue and folded to napkin size.

The symptoms parents could look for, Mrs. Wren said, are hacky coughs and paleness. "One kid wrote in a notebook 'The best thing is you don't get sick like with whiskey.' He was telling another girl how he had been sniffing the night before."

While the total number of students involved may be small, they seem to be influencing each other in their experimentations. "The boys and girls travel together, and if one starts to use

it, the other will." Mrs. Wren said she "expected" sex experimentation and activity followed in many instances as in the use of alcohol too.

Bill Casey, another probation counselor, agreed the instances occurred in groups. "I've got 10 boys who run around together who are involved," he said. He reported instances from Aycock and Carroll.

R. J. Proctor, the principal at Charles B. Aycock, said: "We've not had one incident at the school." He had heard about it outside the school, however.

"We've caught some boys carrying glue, but they apparently hadn't used it at the school," he said. "We've also heard rumors about it going on outside the school. I understand some of the high school kids are doing it—I hear this from my own students."

Other schools contacted had no involvement with incidents at the school. Clifton Edwards, principal of Josephus Daniels Junior High said, "We've not had any problems at all. We have the normal day to day disciplinary problems, but so far we've not had that."

Joseph Holliday, the principal of Needham Broughton concurred. "I have no knowledge and no indication of anything like this going on," he said.

Casey, the probation officer, said the Ben Franklin Store, near Aycock, had reported incidents involving students and glue. As a result manager B. S. Baker has started having students sign when they buy the glue.

"I'm having them do that," Baker said, "to discourage them. For some reason I had students buying five and six tubes at the time, and I got suspicious. Now, they have to sign, and they can only buy one tube at the time. Some have refused to sign and we haven't sold it to them."

Baker said, "I first became aware of the seriousness of the problem when one of the school secretaries called me.

Of course, I was willing to do anything I could to help."

Overnight Baker's glue sales plummeted. From selling a gross of glue a week, he now sells about a half dozen tubes in that time.

Several Raleigh youth centers have been adversely affected by reported incidents. Phillip Brown, another counselor, said the Jones Street Y.W.C.A. had been having some minor problems. "Don't mistake the meaning," he said, "it is still a good place for kids to go, but there is an undesirable element occasionally occurring." How much of this is directly related to the glue-sniffing is debatable. "We have had reports of it happening in the bathrooms," he said. "We need more parents to supervise places such as this," the counselor agreed. "The parents come and drop kids off, and pick them up at 11. What has happened in the meantime they know nothing about."

"My girls back from training schools won't go there," Mrs. Wren said. "They say it's too rough and they'll get in trouble."

Brown reported a juvenile transfer case of his from Alabama, a 16-year-old taken to the hospital after taking a large dosage of medicine and chasing it with lighter fluid. "The doctor said the hairs on the inside of his nose had been burned out. It looked like glue-sniffing had done it."

The counselors agreed one reason for the rise of glue-sniffing incidents is the unavailability of drugs to the young students. The secretary in the juvenile office said her brother had reported seeing a student use glue in his class at Millbrook.

Cary Allen, the manager of the Person Street store, said, "I'm no moralist. I know the kids can get hold of a lot of things that can harm them, but I can prevent them getting the glue here, at least." — **Raleigh Times**



John T. Kerr Appointed to New Position

The newly-created position of executive director of the N. C. Association of Nursing Homes authorized by the membership at the March meeting in Raleigh, was filled with the appointment of John T. Kerr of Durham. He commenced work with the Association on May 1. Announcement of the appointment was made by Charles E. Priest, Association president from Fayetteville.

Kerr has been working since the first of the month from the Raleigh offices of John Harden Associates but will move to Durham soon. His duties will include staff responsibilities, governmental relations, legislative activity and public relations.

A graduate of the University of North Carolina at Chapel Hill, Kerr was formerly director of the health careers program for the North Carolina Hospital Education & Research Foundation in Raleigh and public relations director for the United Fund of Durham. A veteran of World War II and the Korean Emergency, he holds the rank of Commander in the Naval Air Reserve. He is a Rotarian, a Presbyterian and the commander of the Durham Squadron of the Civil Air Patrol.

Study of Scientific, Legal and Ethical Heart Transplantation

A thorough investigation will be launched by the American Heart Association into the scientific legal and ethical problems resulting from human heart transplantation in order to develop a detailed guideline for the medical profession and the public. This study was proposed by the newly-named Committee on Ethics of the Association, the Chairman of which is Dr. Eugene Stead of the Duke University Medical Center.

The Ethics Committee expressed its approval of three basic criteria as set forth recently in a statement on heart transplantation issued by the Board of Medicine of the National Academy of Science. These criteria are summarized as follows:

1. Cardiac transplantation, as a therapeutic trial, requires careful advance formulation of an overall plan of study, including provision for systematic follow-up of the heart recipient throughout his lifetime.

2. Institutions should proceed cautiously and permit the performance of heart transplantation only when the surgical team can meet the most stringent and exacting criteria of technical and scientific capability.

3. Meticulous scientific standards must be set for the selection of donors and recipients, which should be confirmed by "peer groups" of physicians and scientists not directly attached to the transplant team.

The Committee went on to state that the patients selected as heart recipients "must be in a hopeless state after all other forms of reasonably indicated therapy have failed."



Mrs. Helen Miller Receives National Nursing Award

Mrs. Helen Sullivan Miller, chairman of the Department of Nursing, North Carolina College, Durham, won one of nursing's highest honors — the Mary Mahoney Award for outstanding contribution to integration in nursing. The award, offered biennially, was presented at opening ceremonies of the American Nurses' Association convention in Dallas, Texas.

Mrs. Miller has devoted most of her life to the cause of integration and equal opportunity. She has led the integration of the student body of the Department of Nursing at North Carolina College, a school with a predominantly Negro enrollment. Mrs. Miller has been chairman of the department since 1956; in 1958 the first white applicant was admitted to the program, and now there is an enrollment of 17 white students. This was accomplished without a simultaneous decrease in the number of Negro enrollees.

Under Mrs. Miller's guidance, the program has changed from a specialized program in public health nursing to a baccalaureate program for nursing. About one-third of the student graduates are white, and the faculty, also, is fully integrated.

Mrs. Miller has long been in the forefront of activities geared to integration and equality. She was one of the first Negro nurses to be employed by the Georgia State Department of Public Health. She was the first and only nurse for Randolph County in Georgia, where she provided nursing services to all with the help of Negro and white teenage volunteers.

Gonorrhea Rise Cited at Hearing

Gonorrhea is 'out of control' in the United States, the director of the National Communicable Disease Center has told a House appropriations subcommittee.

Dr. David J. Sencer testified that "there has been a 12 per cent increase in reported gonorrhea cases in each of the last few years. You can say it is increasing and increasing dangerously."

Sencer said his agency asked for an increase of \$1.7 million in its funds for fighting the venereal disease, but that the budget bureau scaled the request down to \$157,000.

"We have adequate treatment for it," he said in March 11 testimony released yesterday but added that "the problem is we cannot diagnose it in females as in males." "We found in limited studies that in certain population groups 35 per cent of the women are silent carriers of the disease and we know we do not have the tools for control yet," Sencer testified.

Asked whether syphilis is also out of control, Sencer replied: "The incidence has stopped increasing. It has not turned the corner and gone down. Here our major problem is not being unable to diagnose it but getting it reported. Only about 25 per cent of the syphilis cases being treated by private physicians are being reported."

NCOA Analysis Shows Older Voters Determine Outcome of Elections

The votes and political activity of older people can determine the outcome of this year's elections, according to a public policy bulletin issued today by the National Council On the Aging. The bulletin was mailed to all members of Congress and governors and made available to all candidates for public office.

Figures cited by the Council show that in the 1964 election persons 65 and older cast more than twice as many votes—11 million against five million—as those between 21 and 24.

The analysis also showed that persons 45 or over constitute about one-half of the entire voting population, but in 1964 they cast about 3,500,000 more votes than those under 45.

As people get progressively older,

they are more likely to vote, the Council noted. Only about half of those in the 21-24 age group voted in 1964, compared to more than three-fourths of those between 45 and 65.

Projecting the 1964 percentages, the Council predicted the following total votes by age group this year: 21-34, 21,899,000; 35-44, 17,364,000; over 45, 43,854,000.

The Council also cited a recent Gallup Poll which showed that only 48% of those 21-29 are registered to vote, compared to 74% of those 30-49 and 84% of those 50 and older.

A state-by-state breakdown showed Iowa with the highest percentage of potential voters over 65 (19.7%), and Alaska with the lowest (4.0%). Half of the states have more than 15.5%.

The policy bulletin urged candidates to encourage older people to become active in campaigns and listed the major issues which concern them. These include income, inflation, housing, taxation, health facilities, jobs and transportation.

The Council said any candidate for public office may obtain a copy of the Public Policy Bulletin by writing to the National Council On the Aging, 315 Park Avenue South, New York, New York 10010.

Scientists Dr. George W. Anderson (left) and Dr. Paul H. Bell headed research program at Lederle Laboratories which led to discovery of the chemical make-up of thyroid hormone, calcitonin. It may provide new treatments for bone diseases.



Future Role of Voluntary Health and Welfare Agencies?

The future role of the voluntary health and welfare agency in a changing society will be explored during the 1968 convention of the National Easter Seal Society for Crippled Children and Adults to be held in Boston, November 13-16.

Hundreds of professional and volunteer leaders from the 50 states, Puerto Rico and the District of Columbia will gather at the Sheraton-Boston Hotel to examine a variety of other subjects relating to rehabilitation. Among them:

1. Increased emphasis on information, referral and followup programs now being instituted by Easter Seal so-

cieties to assure that help from all sources is made available to those who need it.

2. The constantly changing requirements of service for the handicapped.

3. New frontiers in rehabilitation facilities.

4. Delivery of services to hard-to-reach patients.

5. Programs on public relations, fund raising, man power and reporting.

In addition, meetings of the National Society's board of directors and house of delegates will be held to determine policy and chart the Society's course during the coming year.

Leon Chatelain, Jr., Washington, D. C. architect, is president of the Society. Wayne Glasgow, Nashville, Tenn. is chariman of the House of Delegates, and Sumner G. Whittier, executive director.

Board member Thomas C. Teas, Mason City, Iowa, is chairman of the national convention committee, and Paul Sonnabend, Boston, treasurer, is chairman of the New England host committee made up of Easter Seal affiliates in Massachusetts, New Hampshire, Vermont, Maine, Rhode Island and Connecticut.

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A PRAYER

LORD, Thou knowest better than I know myself that I am growing older, and will some day be old. Keep me from getting talkative, and particularly from the habit of thinking I must say something on every subject and on every occasion. Release me from craving to try to straighten out everybody's affairs.

Make me thoughtful, but not moody—helpful but not bossy. With my vast store of wisdom it seems a pity not to use it all, but Thou knowest, Lord, that I want a few friends at the end.

Keep me free from the recital of endless details—give me wings to get to the point.

Seal my lips on my many aches and pains. They are increasing and my love of rehearsing them is becoming sweeter as the years go by.

I ask for Grace enough to listen to the tales of others' pains. Help me to endure them with patience.

Teach me the glorious lesson that occasionally I might be mistaken.

Keep me reasonably sweet. I do not want to be a saint—some of them are so hard to live with—but a sour old human is one of the crowning works of the Devil.

Help me to extract all possible fun out of life. There are so many funny things around us and I do not want to miss any of them. — AMEN.

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1970 White House Conference

Dr. Joseph H. Douglass of the U. S. Public Health Service was named staff director of the 1970 White House Conference on Children and Youth by Secretary of Health, Education, and Welfare Wilbur J. Cohen.

The Conference is the oldest continuing national meeting convened by the White House. Held every 10 years since 1909, it was first called by President Theodore Roosevelt.

Its purpose traditionally has been to review progress for children and youth over the past decade, and to set new goals for the coming decade based on changing national conditions and advancements in knowledge.

"My conclusion is that if the population problem is to be resolved, government organization must be strengthened and developed so that it can effectively provide the family planning information and services people want and need."

John D. Rockefeller, III

Director, Rockefeller Brothers, Inc.

(Quoted From Family Planning and Population Programs, University of Chicago Press, 1965).

Model Alcoholism Statute to Be Prepared

Award of a contract for legal research in the field of alcohol and alcoholism was announced by Dr. Stanley F. Yolles, Director of the National Institute of Mental Health.

The contract, with the Legislative Drafting Research Fund of Columbia University, calls for a review of laws in effect throughout the country relating to alcohol and alcoholism. Preparation of a model statute dealing with alcohol and alcoholism is also called for.

Acute illness, especially influenza-like respiratory conditions and measles, reached a 10-year low in the year ended last June, it was announced by Dr. Robert Q. Marston, Administrator, Health Services and Mental Health Administration.

The announcement was based on results of a survey just published by the Administration's National Center for Health Statistics. This annual survey is based on interviews involving some 42,000 households and about 134,000 Americans across the nation.



THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

83, 86
June 1968



The Continuing Education Project

A Report to
Public Health Workers
In North Carolina

(See page 5)

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IN MEMORIAM
ALFRED GREGSON CHISWELL
1921 - 1968

The recent accidental death of Alfred G. Chiswell, R.T., who was fatally injured in a two car accident near Raleigh, May 11th, has left many of us who came to know and respect him for his efforts in public health work across the State deeply saddened. The heartfelt sympathy of these many people is extended to his family at this time of great loss.

Al Chiswell came to work with the Tuberculosis Control Section in 1946. During most of his years with the State Board of Health, he was responsible for the complex day to day operation of

the mobile chest X-ray clinics. For much of this time, he lived and worked out of his home in Southern Pines. In large measure, the success of this program was due to his unselfish dedication and desire and through him, his colleagues and at times his family, to see the maximum number of people receive through the medium of a chest X-ray a passport to good health. It is a fitting memorial that there are many who through these efforts owe their health and, in many cases, their lives to the combined activities of this program under the very able leadership of Alfred Chiswell. More recently, the knowledge acquired as a result of this considerable experience was being shared with many local Tuberculosis Control Programs to great advantage for Al Chiswell was now functioning in a consultant capacity and bringing to bear his accumulated technical knowledge for the further prosecution of the aims of tuberculosis control.

His loss is heightened by the fact that he was dedicated in a much wider sense to the virtues of honesty, integrity, loyalty and a regard for truth—things that cannot fail in the long run to command the respect of those whose privilege it is to work with such a man. The cause of Public Health has been more than adequately served by this colleague of ours whose untimely death has shocked and saddened his many friends throughout the State. For those of us remaining, we could do well to emulate the fine example set by Alfred Chiswell, whose name will live on and whose accomplishments in the interests of tuberculosis control in North Carolina will long be remembered. Perhaps though, it will be his personal qualities that will most endear him to the memories of those who knew him.

**From the Newsletter of
the State Board of Health**



Dr. Isa Grant Named Chief of Chronic Disease Section

Dr. Isa Grant has been named Chief of the Chronic Disease Section of the Personal Health Division of the North Carolina State Board of Health, according to announcement by Dr. Jacob Koomen, State Health Director.

Dr. Grant, a native North Carolinian, attended high school in Wilson, North Carolina. She received her Bachelor of Arts degree at East Carolina University and did postgraduate work at Duke University. She received her Doctor of Medicine degree from the Medical College of Virginia in Richmond, Virginia, and after an internship at Wilkes-Barre General Hospital in Wilkes-Barre, Pennsylvania, she returned to the Medical College of Virginia where she did a residency in pediatrics.

After a wealth of experience in the field of child care, including the private practice of pediatrics, Dr. Grant became Chief of Maternal and Child Health for the Commonwealth of Virginia.

Later Dr. Grant completed requirements for her Master of Public Health degree at the University of North Carolina. She then became Director of Public Health in Wake County. For the past several years, Dr. Grant has been Director of Public Health in Chowan, Perquimans, Pasquotank and Camden counties with headquarters at Elizabeth City.

Dr. Isa Grant has earned for herself an enviable place in the field of public health, not only in her native state, but throughout the entire nation. In 1965, she was President of the N. C. Public Health Association and has served in many other capacities to further the cause of public health and to bring to the population of the State better public health care.

This dedicated physician will add greatly to the staff of the Personal Health Division and enhance the programs of public health in the State.

SUNTAN OR SUNBURN?

Skin specialists have predicted that suntanners some day will quit baking their outer hides to a golden brown each summer. The reason for this prediction is that the hazards of suntanning include premature aging of the skin and the appearance of various freckles and blemishes.

The American Medical Association's Committee on Cutaneous Health and Cosmetics warns that year-round exposure or excessive summer tanning can cause a permanent leathery look. People above the mid-30's should think twice before exposing themselves to the drying effects of repeated sunning. The correlation between continual exposure and skin cancer indicates additional danger.

Nevertheless, whatever the future brings, some Americans today still bake in the sun. If you are among this group of sun lovers, the best way to get your summer tan is without burning.

Gradual tanning with a minimum of discomfort is possible for most people. Gradual exposure to the sun is the safest and simplest method of acquiring an attractive tan. As a general rule, ten minutes on a side is enough for the first day, increasing the time by about five minutes on each successive day. If you must bake longer, do it before 10 A.M. or after 2 P.M. since the sun's rays are the strongest during that four hour period. Remember, you can burn on cloudy or hazy days too.

Suntan creams and lotions contain chemical sunscreens which help prevent sunburn by absorbing some of the sun's ultraviolet rays. Choosing an effective sunscreen is difficult. Your best bet is the product made by a reputable manufacturer. For a day at the beach, one coat of lotion is not enough. Apply it as directed, after each swim, and whenever it seems to have rubbed off.

Eyes and hair need sun protection, too. Wear dark glasses, and don a hat. Sun bleaches the hair, and over a time the sun-bleached hair becomes brittle and unmanageable. However, the damaged hair will eventually grow out.

The physical benefits of tanning are almost nil. The only beneficial effect of sunlight, other than the psychological lift of sporting a good tan, is the formation of vitamin D, and the American diet already provides an ample supply.

For some years it has been suspected that rabies can be transmitted under unusual circumstances by the airborne route. Men have died of rabies after working in bat infested caves although they insisted they had not been bitten by a bat or other animal. There is now definite evidence—obtained from a variety of animals—that rabies can be acquired in poorly ventilated bat infested caves by the airborne route.

The importance of airborne transmission in the spread of rabies to large numbers of bats has not yet been determined.

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No. 6

The Continuing Education Project

A Report to Public Health Workers In North Carolina

by
The Project Staff

In the first ETV presentation you were reminded that in substantial part this continuing education program is a North Carolina product. Drs. Roy Norton, Fred Mayes, and John Wright were advisors and supporters from the early planning stage.

The project was pushed forward by Miss Elizabeth Holley, particularly during the year she was president of the Southern Branch. More recently, Dr. Jacob Koomen and Mr. William Herzog have been active members of a nine person Steering Committee.

The staffs of six North Carolina local health departments aided in setting priorities for subject content. Participants in the program have been drawn freely from North Carolina.

Thus, the state has been a heavy backer of the project and the staff wishes to report on progress, problems,

and prospects to all public health workers in North Carolina.

This new approach to continuing education for public health workers may be considered an experiment, a demonstration, or a developmental program, for it is all of these. As such, it was agreed that the approach using state television systems would be used and evaluated initially in three states.

The program was started first by Alabama, and six months later by North Carolina. It is expected to begin in Louisiana six months after North Carolina. Participation of a fourth state, possibly Florida, in which the role of Community Colleges will be explored, is authorized.

Overall plans for the educational programs were evolved with the aid of (1) a Project Steering Committee, (2) an Advisory Committee representing the cooperating universities and health departments, and (3) the Continuing Education Committees of the State Public Health Associations in the participating states.

Initiation in Alabama and North Carolina

One year ago (May 1, 1967) this continuing education project was little more than an opportunity. The Director, on the job for a month, was seeking commitments from universities, agencies, ETV facilities, and individuals for cooperative participation which would make the project a practical possibility. The project's Television Educational Director, Mr. Ronald Lester, was becoming settled in the Southern Branch headquarters in Birmingham. Two additional professional associates were being sought; one, Dr. Donnie Dutton, joined the project eight months later, while the search for the other continues.

It was planned and agreed that the facilities of ETV would be used and that all public health staff members would participate during work time. But to prepare for the initiation of an

ongoing continuing education program for 1500 public health workers in Alabama and over 2,000 in North Carolina was a major task for state and local personnel. It was accomplished through the strong support of the State Health Officers and their senior associates, by the understanding and action of the County Health Officers and county officials, and in North Carolina by Dr. Corrina Sutton who was given the responsibility for administrative management of the program.

The ETV Presentations

The provision of continuing education for public health workers through ETV is unique, but there is a tendency to exaggerate the relative importance of this part of the educational session. By some, the whole program may be regarded as one of "watching television." Some undoubtedly expect entertainment since this is the usual reason for viewing television. The purpose of this program is education. To be effective ETV must hold attention but it should not be compared with programs designed to entertain.

In preparation of an ETV program on a particular subject, it is necessary first to identify and obtain the cooperation of persons generally acknowledged as authorities on the subject. For example, the aid and guidance of the Tuberculosis Division of the United States Public Health Service was sought and generously provided in preparing the two sessions on TB control. The authorities, in conference with project staff, reached decisions as to content.

Ordinarily a minimum of one full work day by two project staff members and usually two or more authorities are necessary merely for the joint planning of one educational session. This is only a start on the detailed preparation.

Always there is the critical question as to what person or group should be requested to do the ETV program.

There was virtually no guiding experience. Public health teachers have had little to do with television. One could hardly request a senior professional to take a "screen test." Not all able teachers project well on television. There is the natural tendency of public health leaders to prepare a paper to be read or a lecture to be given as is so common in public health conferences or in the classroom.

For television a carefully planned informal setting with visual aids or a visual presentation is desired. The preparation for this is exacting for both the ETV teachers and the staff.

To one without prior experience, the complexities in taping a program are a great surprise. The physical facilities are impressive—and very costly. A station staff of six to ten persons is required.

To public health personnel without prior responsibility for a TV teaching session, exactly timed, the taping is a trying experience. One must be prepared for a studio rehearsal, the thirty minute taping and a redoing of it all as many times as indicated (subject to time and cost limitations) if there is reasonable hope of improving the presentation.

Even if the taping goes well, there can be problems later. In Alabama, one Wednesday morning program could not be broadcast since the TV tower was struck by lightning Tuesday night. Even more exasperating, another did not get on the air as scheduled since the tape sent ten days earlier had not reached the studio, and the project staff was made aware of this when a repeat program was put on the air.

We have learned that there are operational problems. Substitute tapes need to be kept available in the broadcast station, and each local group needs to have a plan for a substitute activity in the event of a broadcast failure.

The tapes prepared have been evaluated by the public health workers in Alabama. Only the ones given a medium to high rating will be used in North Carolina. Those with low ratings will be replaced and redone if the subject is retained. Poor reception detracts seriously. Perhaps this can be improved by more effective aeriels. If so, it is hoped these will be installed.

Study Manuals

It has been the view of the project staff that each session has three inter-related components—the study manual, ETV and the group discussion. The first two communicate in differing ways and possibly on differing aspects of the subject. The group discussion draws from these and other sources, and from local experience, for the learning together, the planning and motivation which is its goal.

Hence, it has been the purpose to provide in the study manual either a capsule summary of current knowledge in the subject area or to be one of a two part presentation, the other being ETV. Since it is distributed before the ETV viewing and to counties beyond the reach of ETV in the three states, the manual must be complete and understandable on its own. It is designed to be kept and should be available long after the ETV is a dim memory. It is hoped that each one who receives a manual will have a loose leaf notebook or folder in which the manuals are retained.

The content of the ETV and the study manuals are planned together. The participating authorities and teachers either provide a suggested draft of content or direct attention to the sources of information. It has been a responsibility chiefly of the project director to prepare the manuscripts. These are submitted for review and approval to the ETV teacher or other authority. Before going to the printer

it must be agreed that the two presentations fit together.

Some participants in Alabama have felt that the manual and the ETV were not sufficiently related. In view of these reactions, in North Carolina during the training sessions for discussion leaders, it was indicated to the participants that the study manuals were to supplement the ETV presentation, not just repeat the same information. This was not done in Alabama. You will find also that later manuals include a "preview" of the total educational session which indicates again the interrelation of ETV and the study manual.

There have been helpful suggestions for increasing the interest and improving the value of the manuals. These are desired and appreciated. Reactions are used as a guide for revision and in future planning.

Group Discussion

In the original project proposal as approved there was major emphasis on ETV and a recognition of the need for study manuals. Group discussion was not mentioned. Only gradually was the high importance of this component fully appreciated. Now it is considered potentially to be the most important part of the educational session. The value of this continuing education program depends substantially on local discussion leaders and your effective participation.

In planning for the initiation of this continuing education program in any state a consideration of high importance is the selection of those who will give local leadership to the program. This was approached differently in Alabama and North Carolina. In the former the one who was acting as the state coordinator of the program was able to take time to visit each county health department, to discuss the program and obtain the recommendation of program coordinators and discussion

leaders and to get their agreement before they were designated by the local health officer. This began to create the realization that the program was their program and the degree of its success depended on them.

In North Carolina decisions were made much more quickly under pressure of time. State personnel acquainted with local workers identified and recommended prospective program coordinators and discussion leaders. This led to a general but erroneous impression that responsibility for this educational program was being assumed in a central office.

In marked contrast the attitude desired was that it was a cooperative endeavor requiring the participation of each local health officer and health department, and of comparable persons at state level. Despite this basis for some misunderstanding, almost all of the persons suggested, or alternates selected by the health officers, were on hand for one of the ten regional leadership training sessions.

The instruction provided by Dr. Donnie Dutton and either Dr. Eugene Watson or Dr. Edward Collins was well received. The expressed regrets were that this training could only be made available to such a small proportion of the health workers.

There is a recognition by some, possibly many, that it requires practice to attain a favorable group discussion. There are those who sit silently or make their whispered comments to their neighbor. There are leaders who "lecture." There are many who think that asking questions and getting answers is a good discussion. Certainly there will be room for improvement in the group discussions in the months ahead. Their value will depend on the attitudes of group members. Even one person with obvious indifference may mar a session. Also one with enthusiasm, par-

ticularly if leading the discussion, can infect the group with enthusiasm. The need is for a deep feeling of responsibility by all for the success of group discussion.

Evaluation

The first concern was to obtain an early indication of the reaction to the individual educational sessions. The simple evaluation sheets provide this. The striking feature in Alabama has been the wide range in reactions. No session was so favorably received that it did not have some who felt it was low in interest and value. Also even the weakest sessions were of very high or high interest to some. It was realized that the opinions of administrators and project staff could be out of line with the majority reactions. Each week the receipt of the evaluation sheets is awaited with much interest.

From the question and answer programs you will know your questions are studied and summarized, and those most commonly asked will be used. In addition your comments are given close attention, particularly the critical ones.

The need for more adequate evaluation is increasingly clear. It is anticipated this will be a part of programs beginning in the fall.

A Look to the Future

Programs began with a consideration of interpersonal relations since this subject was given highest priority by local health department personnel. In the fall areas of major activity in communicable disease control, environmental health, maternal and child health, comprehensive health planning, and others will receive attention.

A means has been found of taking continuing education to every worker in every health department within reach of ETV. Health leaders in universities, schools of public health, agencies, and health departments have

responded with a readiness to participate. Can the full potential of this program be developed?

Our future largely will be determined by attitudes. Some may have had the feeling that this continuing education program is something being done **to** you. It is an activity in which you were expected to participate. Others may have thought of it as a program provided **for** you. If so, you may be only a passive recipient. Goals can be attained only by working together. Think and speak of this as your own program which, is being done **with** cooperative assistance, not **to** or **for** but **with**.

This sharing calls for greater emphasis in at least three activities:

- (1) **The State Public Health Association** of each participating state has a Continuing Education Committee. Your chairman is Dr. Corrina Sutton. Its major function is to be the spokesman for all public health workers. Future programs as in the areas mentioned and in administration, adult health, mental health and in other untouched fields must be planned. What is provided will be the programs requested by you if your continuing education committee is an effective spokesman for you.
- (2) **Cooperating with this committee**, the project staff proposes to seek your personal recommendations through a questionnaire which will be distributed as early as practicable. The individual recommendations of every public health worker on many questions is needed and will guide future action.
- (3) **The real value of the program** must be measured. This demands a relatively precise evaluation. Let there be the attitude that we

each will gain as much as possible from the program and will gladly share in an evaluation which will show to ourselves and to others what has been accomplished.

For Those Beyond the Reach of ETV

It is the purpose to make this program of continuing education available to all public health workers in the state. Where ETV is not yet available the temporary substitute will be regional meetings using film reproduction of selected tapes. Individual study of the manuals and group discussions are recommended also.

The project staff has been advised that plans have been developed for providing statewide ETV coverage in the months ahead.

Summary

The public health workers of North Carolina are initiating a program of continuing education which could have high significance to the future of public health. The cooperative participation of health leaders in universities, agencies and health departments seemed assured. Despite the inevitable weaknesses of a new effort, its rich potential is evident. Its full value must be attained. The future depends substantially on the public health workers of North Carolina and the other pilot states, and is a heavy responsibility on the project staff which gladly accepts this as a challenging opportunity.

Albert V. Hardy, M.D., Dr.P.H.
Project Director

Ronald L. Lester, M.P.H.
Television Educational
Director

M. Donnie Dutton, Ph.D.
Adult Education Director

Frederick W. Hering, M.S.P.H.
Executive Secretary,
Southern Branch

CHARACTERISTICS OF HUSBANDS IN THE UNITED STATES, MARCH 1967

Characteristic	Age of Husband, in Years							
	14 and over	14-24	25-29	30-34	35-44	45-54	55-64	65 and over
Husbands—number in thousands	45,191	3,081	4,679	4,478	10,318	9,686	7,100	5,849
—percent distribution	100.0	6.8	10.4	9.9	22.8	21.4	15.7	13.0
—percent of all men in age group	67.9	18.4	82.9	85.5	88.9	89.1	85.2	72.5
Age of wife—percent*	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
14-24	12.0	92.1	44.0	8.8	1.3	.3	.1	.1
25-29	11.1	6.5	49.1	39.8	6.2	.6	.2	.1
30-34	10.7	.9	5.4	41.5	23.5	2.3	.5	.1
35-44	23.5	.3	1.3	9.2	62.4	33.1	5.2	1.0
45-64	34.3	.2	.2	.7	6.5	63.4	89.2	39.9
65 and over	8.4	.0	.0	.0	.1	.3	4.8	58.8
Residence—percent in 1966	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Metropolitan areas	64.1	62.4	64.5	66.5	66.0	65.6	62.4	59.3
In central cities	29.2	31.1	30.1	29.0	26.8	29.0	30.6	30.6
Outside central cities	34.9	31.3	34.4	37.5	39.2	36.6	31.8	28.7
Nonmetropolitan areas	35.9	37.6	35.5	33.5	34.0	34.4	37.6	40.7
Living arrangement—percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Living with wife	95.7	93.8	96.3	96.3	96.0	96.0	95.0	95.2
Own household	94.0	87.1	94.1	95.0	95.0	95.1	94.0	93.3
Relative's household	1.5	6.3	1.9	1.3	.9	.8	.8	1.8
Nonrelative's household .....	.2	.4	.3	.0	.1	.1	.2	.1
Not living with wife	4.3	6.2	3.7	3.7	4.0	4.0	5.0	4.8
Own household with relative present .....	.4	.6	.3	.4	.5	.6	.4	.4
Own household with or without nonrelative present	1.3	.9	1.0	1.0	1.0	1.1	1.9	2.0
Other	2.6	4.7	2.4	2.3	2.5	2.3	2.7	2.4
Number of own children under 18 years of age—percent in 1966* ..	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No children	42.8	40.5	19.8	9.7	12.3	42.8	81.7	96.2
One child	17.3	36.0	24.2	14.0	15.4	24.5	11.9	2.4
Two children	17.6	17.2	31.0	29.2	26.5	16.7	3.7	.7
Three children	11.1	4.8	15.7	22.8	21.3	7.8	1.4	.3
Four or more children	11.2	1.5	9.3	24.3	24.5	8.2	1.3	.4
Own children under age 18 per 100 husbands	133	88	171	248	239	115	28	6
Labor force participation—percent in 1966*	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
In labor force	87.2	96.5	98.4	98.8	98.1	96.6	86.7	29.8
Employed	85.1	93.7	95.9	96.6	96.4	94.6	83.9	28.6
Unemployed	2.1	2.8	2.5	2.2	1.7	2.0	2.8	1.2
Not in labor force	12.8	3.5	1.6	1.2	1.9	3.4	13.3	70.2

* Excludes husbands with spouse absent.

Note: Data relate to civilian population, and members of the Armed Forces who live off post or with their families on post.

Source of basic data: Reports of the Bureau of the Census and the Department of Labor.

The American Husband

The majority of American men marry and establish their own homes at a relatively early age, and bear the chief responsibility for financial support of a family throughout their working lives. The latest data on the characteristics of husbands in the United States are shown in the accompanying table; members of the Armed Forces are included only if they live off post or live on post with their families.

A large proportion of our married men are at the ages when they begin raising and educating their children. In 1967 over one quarter had not yet reached age 35 and an additional quarter were 35-44 years old. The married men aged 65 and over have been increasing in number, and now exceed 5.8 million, or one eighth of all married men. About 3.3 million of these husbands, many of whom are retired from active business life, have wives who are also 65 years of age or older.

Only about 36 percent of our married men make their home in small urban or rural communities. Almost two thirds live in metropolitan areas (standard metropolitan statistical areas), with the suburbs favored over the central cities.

Virtually all husbands maintain homes for their families. Only about 6 percent either live apart from their wives, or live with them in someone else's household. This latter group is typified by young newlyweds who share living quarters with their parents or other close relative until they are able

to set up a home of their own. Because fewer and fewer young couples find this doubling up a financial necessity, the relative importance of such living arrangement has declined steadily in the past two decades, from about 9 percent of all married couples in 1947 to only 1.7 percent in 1967.

Three out of five married couples have at least one of their own children under age 18 living with them, but the proportion declines as the family matures. When the husband is in his late twenties, four out of five couples are responsible for at least one young child and one in four has three or more children in their care. The head of a moderately large family is most commonly a husband 30-44 years old. Nearly half of the families of this size have three or more children living with them. After the husband's 45th birthday, the number of children in the family decreases sharply: the offspring go off to school, marry, or leave home for other reasons. Nevertheless, there are about 360,000 young children living in families in which the husband is 65 years or over.

At ages 25-44, when family responsibilities are at a maximum, 98 percent of all husbands are in the labor force. The proportion declines with advance in age, but still is almost 87 percent at ages 55-64 years. Thereafter, it drops sharply as increasing numbers retire, become disabled, or find it impossible to obtain employment. Though in most families the husband is the principal bread-winner, an increasing number of wives are supplementing their families' income either by working part time or temporarily, or by resuming a career interrupted while the children were of tender years. At present, in one out of three families both the husband and wife are in the labor force.

—From Statistical Bulletin, Metropolitan Life Insurance Co.

Are Human Tumours Caused By Viruses?

Benign human tumours—warts and molluscum contagiosum—are certainly caused by viruses. It is even possible that these or related viruses occasionally give rise to malignant growth. (Wart viruses from American cottontail rabbits and cattle, which are structurally very similar to human wart viruses, are known to induce malignant tumours in domestic rabbits and hamsters, respectively.) But for the rest the supposition that at least some human tumours are virus-induced is based on analogies with what happens in lower animals. Although these analogies can be highly suggestive, they are not by themselves convincing; and this is why so much time and effort has gone into attempts to establish that certain human tumours are caused by viruses. This effort has also a practical side, because, if an oncogenic human virus were to be isolated, vaccination might be feasible. Under appropriate conditions vaccination can reduce the incidence of virus-induced tumours in laboratory animals, although such procedures may well be difficult to apply in man . . . There is no shortage of animal models; all we need is convincing evidence that even one human malignant tumour is induced by a virus.

Reference: *The Lancet*, May 1968, Page 1142.

Radio Interview With Dr. Neely On PKU

Our guest today is Dr. E. Robert Neely, Pediatric Consultant with the Maternal and Child Health Section of the North Carolina State Board of Health.

In 1965 the General Assembly of North Carolina enacted a law establishing at the State Board of Health a volunteer metabolic screening program for newborn infants in which the first abnormality tested for was PKU.

Q. Dr. Neely, what is PKU?

A. PKU or phenylketonuria is an inherited disease in which an infant cannot use phenylalanine which is an amino-acid or normal substance of protein that we eat. This food substance gets very high in the blood stream of the PKU infant and is deposited in several parts of the body, especially the brain. Early the child with PKU seems normal but after four months or so, he may develop marked irritability, severe vomiting, convulsions (or fits), dry scaly rash, and a musty odor with an increasing appearance of mental retardation or slowness.

Q. How are PKU patients detected?

A. Presently the best way to detect this disease is by mass testing of newborns in public health screening programs and we feel that actual measurement of the blood phenylalanine level is more reliable. There are a few other, less reliable tests including one that doctors can do on the baby's urine in his office or clinic.

Q. How often does PKU occur?

A. As I said before, PKU is inherited which means he gets the disease passed

on from his parents who may have the disease but are probably only carriers of the disease. A carrier is a normal person who if he marries someone who is also a carrier of PKU, they have one chance in four of having a child with PKU. One of every 70 people is a carrier and the instance of PKU varies from 1 in 7,000 births in Utah to 1 in 20,000 births in the Southeastern United States. The incidence in this state thus far is approximately 1 in 20,000 births.

Q. How many PKU children have you found in North Carolina?

A. By screening we have found 8 since our full program started in January 1966.

Q. How many newborns have been tested?

A. In 1966 we tested approximately 69,000 newborn infants or 73% of our births and in 1967 we tested 83,000 or 89% of our births. Since we have a voluntary program in North Carolina, methods other than our state program may be used for screening, and two of our larger hospitals do their own screening in their hospital laboratory. If we add those to our tests, 93% of all our newborns were tested.

Q. What happens after a high PKU test is found?

A. All test results falling above our screening level are returned to physicians and hospitals, sending it in asking for a repeat test. After the repeat test is completed, and if we feel the results are compatible with PKU, we request that the child be admitted to one of our University Medical Centers for further diagnostic evaluation. I might say here that frequently there are several repeats before we send the patient to a center and most of our PKU infants have had extremely high blood levels of phenylalanine.

In the Medical Center a team approach of physician, nurse, dietician, and usually, social worker evaluate the

child and family. Genetic evaluation of this family and the relationship of relatives to being possible carriers is needed to help in awareness and control of future cases in the family. After evaluation, diagnosis, and starting of treatment, the patient is referred back to his family physician or public health clinic to be followed locally with periodic visits back to the University Medical Center for consultation and advice to the local people.

The cooperation between physicians and public health personnel has been excellent with the Medical Centers and in one instance a public health nurse had an exhausting time counselling one family in following dietary orders on a child.

Q. How is PKU treated?

A. By a special diet which is low in phenylalanine, the offending food substance. All protein foods in nature, including milk, are too high for use as food in these patients so an artificial milk formula is made by one of the drug companies. The taste of the formula and the low phenylalanine diet in general is not very tasty, so our consulting dietician and nutritionists at the State Board of Health have helped in developing a broader variety of better tasting food combinations. Consultants at the State Board of Health can be contacted for help with these PKU patients. The formula is quite expensive and we help some of the low income families to purchase the formula. It is felt that the diet will prevent mental retardation and the other mentioned problems in this disease.

Q. What is the future of metabolic screening in the newborn?

A. There are several diseases that could be tested for and we now have two other tests ready that we hope to add within the next few months. Possibly we can talk about these at a later time.

American Academy for Sanitarians Growing

The American Intersociety Academy for Certification of Sanitarians, Inc., has shown very encouraging and substantial growth during the current year. Professional Sanitarians already certified as Founder Diplomates together with applications on file number about one hundred thirty. Through a recent change in the By-Laws, applicants for certification as Founder Diplomates now have until December 31, 1968 to apply. The original closing date was June 30, 1968.

The Academy was incorporated in March 1966 and began accepting applications in January 1967. The purpose of the Academy is to certify and give recognition to professional sanitarians whose educational background, competence and leadership have been demonstrated to be of outstanding quality in the field of Environmental Health.

For certification as Founder Diplomate, the minimum qualifications are a baccalaureate degree with not less than forty semester hours of academic credit in the physical and biological sciences plus twelve years of acceptable experience, eight of which have been in responsible charge of work. Other provisions are made for professional sanitarians holding a Masters or higher degree in which the number of years experience is reduced but an examination must be successfully passed in the general field of Environmental Health.

The Academy is an outgrowth of recommendations by the Sanitarians Joint Council the membership of which is composed of representatives from the International Association of Milk, Food and Environmental Sanitarians, the National Association of Sanitarians and the American Public Health Association.

Professional sanitarians wishing more complete information about the Academy, its membership requirements and its objectives should address a request to Darold W. Taylor, Secretary, 2101 Wakefield Street, Alexandria, Virginia 22308.

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Health Notes

The percentage of people 65 and over enrolled in the doctor bill insurance part of Medicare went up from 92 to 95 percent during the 6-month open enrollment period that ended April 1, Robert M. Ball, Commissioner of Social Security, announced.

The Board of Directors of the North Carolina Heart Association meeting in Winston-Salem on May 29 approved the proposed budget of \$122,500 for research. These funds will be allocated to support cardiovascular research in North Carolina.

In addition to the \$122,500 Heart Fund dollars designated by the North Carolina Heart Association, additional research funds from the American Heart Association will also be used in North Carolina.

The majority of the funds approved by the Board for research will be awarded in Grants-In-Aid.

Recommendations for vaccination of travelers against three internationally important diseases—cholera, plague, and typhus—have been released by Dr. Robert Q. Marston, Chief of the Health Services and Mental Health Administration of the Public Health Service.

These recommendations result from recent study of the diseases by the Public Health Service Advisory Committee on Immunization Practices. They have been developed in accordance with international requirements and have become the accepted standards for the Foreign Quarantine Program of the Public Health Service.

N. C. Heart Association Elects State Officers

Dr. James A. McFarland of the Duke University Medical Center in **Durham** was elected President of the North Carolina Heart Association at its Annual Luncheon at the Robert E. Lee Hotel during the 19th Annual Meeting and Scientific Sessions held in Winston-Salem. Dr. McFarland succeeds Dr. Madison S. Spach of **Durham**.

Dr. McFarland, an internist who recently joined the Duke Staff and Regional Medical Program, was previously in practice in **Rutherfordton**, North Carolina.

Dr. Henry S. Miller, a physician from **Winston-Salem**, was elected Vice-President and President-Elect of the Association.

Also elected as officers of the Association were R. B. Boyd of **Charlotte** as Secretary and James F. Lane of **Chapel Hill** as Treasurer.

Elected for membership on the Board of Directors for three year terms were the following: Dr. L. L. Anthony, **Gastonia**; Mrs. Paul Collins, **High Point**; Mrs. John Grogan, **Eden**; Dr. James R. Harper, **Chapel Hill**; Dr. Robert N. Headley, **Winston-Salem**; Mrs. W. J. Kennedy, III, **Durham**; Carlyle Lewis, **Madison**; Dr. David L. Phillips, **Spruce Pine**; Mrs. I. T. Valentine, Jr., **Nashville**; and Jack Watson of **Lumberton**.

The following members were elected as Delegates to the 1968-69 Assembly of the American Heart Association to represent the North Carolina group: Dr. J. Logan Irvin, **Chapel Hill**; Fred W. Klein, **Eden**; James F. Lane, **Chapel Hill**; and Dr. Henry S. Miller, **Winston-Salem**.

Dr. J. Logan Irvin of Chapel Hill will serve as Chairman of the Board of Directors and Mr. Fred Klein of Leaks-ville will serve as Vice-Chairman and Chairman-Elect of the Board.

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"Peanuts" Warns Children About "Lazy Eye"

A free comic book featuring the nationally syndicated "Peanuts" characters that warns children and their parents about a form of blindness which strikes the young, has been released by the U. S. Public Health Service's National Center for Chronic Disease Control.

Public health officials worked closely with Charles M. Schulz, creator of "Peanuts" in preparing the 13 episode booklet. The cartoons are designed to encourage early eye examinations for children as a precaution against amblyopia ex anopsia—commonly called "lazy eye," which can lead to blindness in one eye if left uncorrected.

"Security Is An Eye Patch" shows cartoon character Sally Brown getting an eye examination and learning she has amblyopia ex anopsia. She is given an eye patch to wear over her good

eye to make her "lazy eye" stronger. This is a common treatment for "lazy eye," a condition in which the two eyes do not see with the same degree of clarity and the poorer one is not stimulated to develop.

The booklet follows Sally's daily adventures with playmates Linus, Snoopy, and Charlie Brown and tells how the eye patch helps her win over "lazy eye".

An eye examination is the only way to detect "lazy eye" in young children, public health physicians point out. A temporary eye patch is often the only treatment needed to correct the condition if it is discovered early enough. Blindness in the "lazy eye" can result if it is left unattended and it is emphasized that the condition must be discovered well before the age of six.

The National Center for Chronic Disease Control is distributing single free copies of "Security Is An Eye Patch." They are available by writing to:

"Security Is An Eye Patch"
National Center for Chronic Disease
Control
4040 North Fairfax Drive
Arlington, Virginia 22203

V. 83, # 1 July 1968



THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

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DIVISION OF
HEALTH & HUMAN SERVICES



Child Safety

Here is an accident in the making. This baby should not have been left on an adult bed with only his little brother to look out for his safety. It's too easy for the baby to crawl to the edge of the bed or roll over and tumble onto the floor. And little brother should not be expected to prevent this potential accident (National Safety Council Photo).

(See article beginning on page 3)



Hartwell B. Rogers Named Public Information Officer

Hartwell B. Rogers has been named Public Information Officer for the North Carolina State Board of Health, according to announcement today by Dr. Jacob Koomen, State Health Director. Mr. Rogers assumes his new duties on August 1, 1968. He succeeds Dr. Edwin S. Preston who resigned some months ago.

Mr. Rogers, a native of Henderson, N. C., has an extensive background in public information, encompassing writing, editing, press releases, radio and television. He was Executive Director for North Carolinians for Better Libraries, Inc., before this agency was dissolved recently. He has served with North Carolina State University, Carolina Power and Light Company and WRAL Radio-Television Station in public information and public relations capacities.

Mr. Rogers attended Elon College, East Carolina University and North Carolina State University. He is a member of the Raleigh Public Relations Society and the N. C. Library Association. He resides at 3508 Woodlawn Drive.

Miss Parrish Is Named Physical Therapy Chief

Dr. Jacob Koomen, State Health Director, has announced the appointment of Miss Anne Parrish as Chief of the Physical Therapy Section of the State Board of Health. "Miss Parrish is eminently qualified to assume leadership for this important public health program," Dr. Koomen said.

A native of Franklin County, Miss Parrish attended Meredith College and received a B.S. degree from the University of North Carolina at Greensboro. She received her certificate in Physical Therapy from the University of Wisconsin and has been with the North Carolina State Board of Health for more than 15 years.

The Physical Therapy Section will provide consultation, training and direct services in a number of public health programs, such as Crippled Children's services, Chronic Diseases and Home Health Care.

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Guest Ed.—Edwin S. Preston, M.A., LL.D.

Vol. 83

July, 1968

No. 7

Don't Let Your Baby Be A Fall Guy

"Don't let your baby be a fall guy."

These words of advice come from Dr. Harvey Kravitz, a pediatrician who has discovered that infants tumble from high places much more often than has been suspected. Dr. Kravitz's source of information is a recently completed study financed through a grant from the National Safety Council.

Of the 536 infants involved in this study, 255, or 47.5% fell from a high place such as an adult bed, a crib, or an infant dressing table during their first year of life.

"We were surprised to learn that the percentage was so high," says Jerry Driessen, a researcher at the National Safety Council who worked with Dr. Kravitz. "If all infants in the country follow the same pattern as those in our study, we can assume that during this year, 1,750,000 babies will fall at least once during their first year of life."

And falls may be even more frequent than this study shows . . . Babies who were seriously injured from a fall most likely were treated in the Neurology Clinic of a hospital. But this study was partly based on discussion with parents who came to a general pediatric clinic, and would not have included those parents who bypassed the Pediatric Clinic to go to the Neurology Clinic because their child was seriously injured.

There is another reason why falls may be more frequent than the study indicates.

"If a baby falls while a baby sitter or maid is in charge," says Dr. Kravitz, "the accident may never be reported, since the person responsible may be afraid of getting in trouble with the parents. Likewise, some parents are afraid of telling the doctor that their baby fell. They think he will blame them for the accident."

But doctors have another interest in finding out about infant falls. They know that a fall can be very harmful to a baby . . .

and he cannot be helped unless the doctor knows he has fallen.

"Injury from a fall can be a serious business for an infant," says Dr. Kravitz. Unfortunately, babies seem to fall head first. When a baby is very young his brain is growing rapidly, the skull has a thinner wall than at any other time of life, and damage to the head at this early developmental stage may interfere with all later learning.

Dr. Kravitz and his associates learned that only 34 of the 255 infants who fell, or 13% of them, were less than five months of age. This is not surprising, though, since babies are not very active until then. They get into trouble when they begin to roll over, sit up, and even stand after having been placed lying down. Once the baby can pull himself to a standing position by holding on to something, he starts to climb. The trouble comes because parents are not prepared for all this activity, and they may underestimate the danger of the baby's falling.

A more surprising result of the study was that 82 babies (or 32% of those who fell) tumbled from furniture designed specifically for infants. Ironically, most of these accidents could be prevented if manufacturers would pay more attention to infant safety. The most common preventable accident (35 out of 51 falls from poorly designed baby furniture) occurred when a baby climbed out of a crib even though the sides were up. The researchers suggest that much more attention be given to designing cribs that take into consideration the growth and development of infants. They suggest that cribs be designed so that the mattress can be lowered closer to the floor and the sides raised higher.

To baby-proof cribs already on the market, the researchers offer these suggestions. Cover the top of the crib with netting. Since this is often done in hospitals, the local hospital is a good place to purchase the appropriate netting. Mothers also should be sure not to put large toys or boxes in the crib with the baby, since he might stand up on them and get a head start over the side of the crib.

Another piece of baby furniture involved in accidental falls is the infant dressing table (27 out of 82 falls from infant furniture), often used by mothers to place the baby on while he is being dressed or his diapers are being changed. Dr. Kravitz believes that manufacturers could make these safer by adding sides to the table surface so that infants could not roll off. The table might also have a concave surface instead of a flat one.

Dr. Kravitz reminds mothers that when they reach down to get something out of the drawer while the baby is perched on top of the table, they should keep one hand firmly planted on the child. He also suggests, "If the doorbell rings while you are dressing your baby and you must leave the room, strap the baby on the dressing table. Better yet, take him with you."

But human error is also a crucial factor in infant falls. In fact, most falls in the study were caused by an error in judgment on

Child Safety

This mother makes two mistakes as she goes to answer the door. First, she should have strapped the baby in his infant seat before she turned away. Second, she could have played it even safer and taken the baby with her.



This time the mother has the right idea. She carries the baby with her to answer the door instead of leaving him alone. (National Safety Council Photos)

the part of the mother, an error that she made partly because she was not aware how dangerous a fall could be to her baby.

"Never, never leave a baby alone unless you are sure that he cannot hurt himself," cautions Dr. Kravitz. "Don't trust your baby to keep still for even a few seconds, and don't trust him to the care of a little brother or sister. Remember that a baby lying calmly on the middle of your bed can wriggle to the end and fall off in a much shorter time than it takes for you to answer the phone. A baby happily playing in an infant seat can rock to the edge of the table and fall off long before you have time to give your order to the milkman."

Dr. Kravitz, who is on the staff of Northwestern University School of Medicine, Chicago, Illinois, was assisted in his study by Gerald J. Driessen, Ph.D., Director of The Safety Research Information Service, National Safety Council, Chicago, Illinois, and by Raymond Gomberg, M.D., and Alvin Korach, M.D., two pediatricians on the staff of Lutheran General Hospital, Park Ridge, Illinois.

The researchers conducted their study in two separate parts. First they questioned parents of 200 children admitted for a variety of reasons to the general pediatric clinic of a hospital in a large city (Children's Memorial Hospital, Chicago, Illinois). The children ranged in age from 10 months to 2 years. Their parents were asked to recall whether their child had fallen during his first year of life, and to describe what they remembered about the fall.

In the second part of the study the pediatricians worked with parents of 336 new infants. The parents were asked to report each time their child fell during his first year of life, as soon as possible after the accident. These patients lived in the suburbs and were seen in the pediatricians' private practice.

The researchers found some differences in the accident histories of urban and suburban infants. Babies from the city were more likely to fall from an adult bed (81 urban babies versus 22 suburban ones), while suburban babies were the only ones who fell from infant dressing tables (27 suburban babies fell from these tables, but not a single urban baby).

The researchers suspect that this marked difference was caused by mothers using different kinds of furniture to put the baby on while dressing him. Suburban homes usually have a dressing table specifically designed for infants. But people in the city are not likely to own infant dressing tables, and the mother usually puts the baby on an adult bed to dress him.

"The most important thing we learned by doing this study was that many, many infants fall before they reach one year of age," concludes Dr. Kravitz.

"Mothers of young infants should be impressed to learn that their babies have a 50-50 chance of falling before they are 12 months old. But if a new mother will follow the safety precautions already discussed, there is a good chance that she can prevent her baby from becoming a 'fall guy.'"

North Carolina Family Life Council, Inc.

Tentative Program

21st Annual Conference

Hotel Robert E. Lee, Winston-Salem Oct. 6-8, 1968

THEME: "IT'S HAPPENING: THE URBAN IMPACT"

October 6—Sunday Evening Opening Session—SPERRY AWARD BANQUET

Address: "Politics and The Family"

THE HONORABLE BROOKS HAYS, Washington, D. C. Special assistant to President Johnson (and President Kennedy); director Ecumenical Institute, Wake Forest University; head of Southern Committee on Political Ethics (SCOPE); visiting professor at University of Massachusetts and professor of government at Rutgers University; former president Southern Baptist Convention; former congressman from Arkansas.

October 7—Monday Morning

Address: "Family Trends in North Carolina"—a demographic presentation, DR. JOSEPH HIMES,, sociologist, North Carolina College, Durham.

Discussants: Implications—Dr. Clark Vincent, Director, Behavioral Sciences Center, Bowman Gray School of Medicine, Wake Forest University, Winston-Salem. Dr. Elizabeth Corkey, Assistant Director, Charlotte-Mecklenburg Health Department The Reverend Alvard Beardsley, Chaplain, Hollins College, Roanoke, Virginia

Lunch 11:30-1:00 Open for special group meetings, own arrangements

Monday Afternoon

Address: "Urbanization and Changing Family Styles" DR. DAVID MACE, Bowman Gray School of Medicine, Department of Genetics and Preventive Medicine, Wake Forest University; President, Sex Education Information Council of the United States; Vice-President of the International Union of Family Organizations since 1963; formerly co-executive director (with Mrs. Mace), American Association of Marriage Counselors; noted author; former president, National Council on Family Relations.

Workshop-Field Trips on the subject of: Poverty, race, mental health, family planning, sex education and the schools—Mrs. Johnny McLeod, M.D., Charlotte; recreation and leisure, crime and delinquency, health—Mr. Marshall Abee, Director, Community Health Services, Greensboro; day care—Miss Mary Elizabeth Keister, Ph.D., U.N.C. Greensboro; religion.

Monday Evening

Address: "Farm Roots of City Disorders" DR. C. E. BISHOP, Vice President, Greater University of North Carolina, Chapel Hill; Chief, President's Commission on Rural Poverty.

October 7—Tuesday Morning

Symposium: "Workshop Leaders Tell It As It Is"

Address: "Emerging Trends in the American Family" DR. WILLIAM KENKEL, President, National Council on Family Relations; professor, sociology and rural sociology, University of Kentucky, Lexington.

President, Mrs. Kate Garner, Greensboro
Publicity Chairman, Leo Hawkins, Raleigh

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ANNUAL MEETING
N. C. Health Council, Inc.
Hotel Jack Tar — Durham
December 3, 1968 - 10 A.M. - 4 P.M.

In this annual meeting, the Council, composed of 65 State and area-wide organizations concerned with health, will give emphasis to the role of the voluntary health associations in North Carolina.

Edwin S. Preston, President

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THE HEALTH BULLETIN

The Official Publication Of The North Carolina State Board of Health

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It is evident that health care is reaching the stage where an increased measure of control and coordination is essential. We can no longer tolerate the gaps and inefficiencies resulting from unorganized decisions to provide service. In some communities, health services are not readily available, even to save life; in other areas hospitals have, for example, developed open heart surgery services and cobalt-therapy units more because they were valued as status symbols than because of demonstrated community need. If we are not going to repeat the mistakes that lead to the fragmentation of the past, we need to develop a mechanism for planning and coordinating our efforts. In a sense, this is the major purpose for the Regional Medical Program and for the Comprehensive Health Planning Legislation."

Quoted From an Editorial in the New England Journal of Medicine, May 2, 1968.

**Comprehensive Health Planning
Is Essential to Meet Today's Needs**



Plaque Presented to Miss Sue Hollowell

Miss Sue Hollowell, daughter of Mr. & Mrs. Bernard B. Hollowell of Bayboro, was presented a plaque from the North Carolina Mosquito Control Association by Mr. C. J. McCotter, a Director of the Association and Pamlico County Health Sanitarian.

Miss Hollowell was given this recognition for her outstanding contribution to the mosquito control program in North Carolina through the many presentations of her 4-H entomology demonstration throughout the state. Her demonstration, for which she was declared State winner at 4-H Club Week in 1967, was entitled, "Mosquitoes, Sometimes Pests, Often Killers."

In addition to her appearances before various groups in North Carolina, Sue was invited to give her demonstration in New Orleans, Louisiana, last April. Her presentation, which depart-

ed from the usual program format, was well received by the approximately 1,000 engineers, entomologists, and directors from various parts of the world. The occasion marked the annual meeting of the American Mosquito Control Association.

This outstanding girl has had a remarkable career as a 4-H Club member for the past 9 years, and as a student, graduating this spring as valedictorian of her class at Pamlico County High School.

The plaque was presented to Miss Hollowell on behalf of Mr. David Hill, President of the North Carolina Mosquito Control Association.

Heart patients traveling to higher climates can help their bodies adjust to the oxygen-poor "thin" air by making the ascent gradually says the North Carolina Heart Association. If this is not feasible, rest before, during and after the trip may help you avoid high altitude discomfort.

THE HEALTH BULLETIN

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Guest Ed.—Edwin S. Preston, M.A., LL.D.

Vol. 83 August, 1968 No. 8

John P. Marston of 900-C Athens Dr., Raleigh, has been appointed to head Health Careers for North Carolina,

a statewide program designed to attract more young people into health professions.

His appointment was announced by Marion J. Foster, ex-

ecutive director of the North Carolina Association, which sponsors the project.

"The need for skilled persons in the medical and paramedical professions remains critical in North Carolina," Foster said, "and our Health Careers staff will be responsible for developing programs to meet the manpower needs of our hospitals and other agencies."

Marston was formerly employed as director of communications for the North Carolina State Board of Science and Technology in the Research Triangle Park. Previously, he had been Assistant Director of the News Bureau at the University of North Carolina at Greensboro. He also has reported for newspapers in Richmond, Va., and Charleston, W. Va.



N. C. Hospital

Association

Appoints

New Workers

Mrs. Ellen R. Walters has begun her work with the N. C. Hospital Association as Staff Assistant. Her position is

a new one and will encompass such duties as **Newsletter** writing, convention planning, public relations activities, and general secretarial duties.



Mrs. Walters was a Commissioner's secretary with the State Utilities Commission before joining the staff. She also was secretary to the superintendent of the Raleigh Public Schools for five years.

Although a native of Danville, Virginia, Mrs. Walters claims Tarboro, North Carolina, as "home." She attended UNC in Greensboro for three years, with studies in liberal arts and the commercial field.

Mrs. Walters and her husband, Tom, Assistant Professor, N. C. State, live on Melbourne Road in Raleigh.

Bateman Named Health Mobilization Chief

Herbert M. Bateman has been named Chief, Health Mobilization Section, Community Health Division, State Board of Health, according to announcement by Dr. Jacob Koomen, State Health Director. This position was previously held by Mr. Samuel J. Hawkins, whose retirement became effective June 1, 1968.

Mr. Bateman is a native of Plymouth and graduated from the University of North Carolina with a B.A. in political science. After service with the United States Navy in the Pacific, Mr. Bateman entered the United States Public Health Service and has served in the public health field since that time.

In 1959, Mr. Bateman was transferred to the newly created Division of Health Mobilization. His most recent position was that of Chief, Division of Emergency Health Service, Maryland State Department of Health.

Mr. Bateman is married to the former Madalyn Walker of Bedford, Virginia. They have three sons: David, 13 years; Donald, 9 years; Darryl, 6 years.

Infant Safety In Autos

A new Public Health Service pamphlet tells parents how to pick out restraining devices used in automobiles for infants and children who are too small for standard seat belts.

The pamphlet is called "Selecting Automobile Safety Restraints for Small Children." It is a publication of the Injury Control Program of the National Center for Urban and Industrial Health in Cincinnati.

"Too many parents are unwittingly risking their children's lives by allowing them to ride without safety restraints," said Jerome H. Svore, Director of the Center.

The pamphlet describes the special types of children's safety seats and harnesses now available on the market. Richard E. Marland, Ph.D., Chief of the Injury Control Program, said every family should have a copy and select and use the proper devices.

For a free copy of the pamphlet write Office of Information, National Center for Urban and Industrial Health, Injury Control Program, 222 East Central Parkway, Cincinnati, Ohio 45202.



In observance of McDowell County's Quasiquicentennial the personnel of McDowell County Health Department is dressed in appropriate costume. Reading from left, those in the picture are Mrs. Doris Phillips, P.H.N.; Mrs. Mariana Stanley, P.H.N.; Mrs. Diane McKinney, Secretary; and Mrs. Barbara Horn, Immunization Aide.

N. C. Association For Retarded Children to Meet

State Convention time is almost here again. We have only a few weeks to get ready for the September 20-21st meeting with all of you in Durham. I hope that each of you will do your best to be sure you attend this convention even if only for the Saturday meeting.

This is the one meeting during the year when your representatives vote to determine the actions to be taken by your NCARC Officers and Directors for the year. Decisions are made at Board and Executive Committee meetings, but the decisions must be approved by you at the State Convention.

The meeting also gives each of you an opportunity to meet people from all over North Carolina—people who have the same problems you have. Some of these may have an answer to your problem. You may be able to help somebody from another unit.

We think we have a very good program planned for the convention—a program of interest and of possible help to you. Our speaker for the banquet on Saturday night will be Dr. Craig W. Phillips. Dr. Phillips is a candidate for the office of Superintendent of Public Instruction for North Carolina. Of special interest to us is the fact that he is a well known Educator, having been Superintendent of schools in Forsyth and Mecklenburg counties. He is very well known for his effort in the field of Special Education. We are fortunate to have such an outstanding man as one of our speakers.

To the members who attend our conventions regularly: Bring at least one member who has not attended a convention before.

All of us would like a chance to meet all of you.

Horace D. Penn

Pulmonary Pediatric Centers Established

As part of a national effort to reduce infant mortality in the United States, the Health Services and Mental Health Administration has announced the establishment of two pediatric pulmonary centers. The centers will seek to develop methods of improving care for babies and children suffering from respiratory disease.

"Respiratory diseases are a major problem for infants," said Dr. Frank W. Mount, Chief of the Administration's Chronic Respiratory Diseases Control Program. "Of 93,000 babies who died in 1965, 31 percent, or 29,000 died because of respiratory disease. Most of these deaths occurred during the first 28 days after birth." During this same year, 14 other countries including Sweden, the Netherlands, and Japan, had lower infant mortality rates than the U.S.

By expanding its interest to childhood respiratory diseases, the Public Health Service will be able to investigate the possible relationship of respiratory disease in infancy and childhood to the development of chronic, crippling lung disease during the adult years. In the past, the Chronic Respiratory Diseases Control Program has concentrated on the control of emphysema and chronic bronchitis, two chronic lung diseases causing more than 25,000 deaths yearly.

Sharing in the \$438,000 project spanning three years are the Los Angeles County-University of Southern California Medical Center and three university hospitals in Philadelphia: Hahnemann Medical College, Temple University, and the University of Pennsylvania. The two contracts are funded from a special Congressional appropriation for pediatric pulmonary centers.

BOOK REVIEW

MEDICAL SOCIOLOGY—A Selective View

Mechanic, David. Medical sociology; a selective view. New York, Free Press, 1968. 504p. \$9.95.

David Mechanic, Professor of Sociology and Director of Graduate Training in Medical Sociology and Mental Health at the University of Wisconsin, manages in his book the difficult task of what might be called "intellectual empathy." The central theme has to do with the complex social implications and behavior patterns when the physician and the patient meet. Dr. Mechanic places himself "in the shoes" of the interactants in this process.

Stating that he foregoes a study of the Sociology of Medicine, Dr. Mechanic examines what happens when the physician, with his varied background (and who has a focus and a point of view in dealing with patients), can be—and often is entirely different in background and expectation as contrasted with the patient. The context of such confrontation is the patient's appearance—at office, clinic, hospital, or a

home—before the physician with what the patient perceives as an illness or a possible illness.

Against the background of these relationships, the multiple factors affecting interactions are examined in terms of the social settings, the behavior norms, and the barriers or helping actions which can lead to the maximum use of the patient-physician relationships.

Interesting chapter discussions which play into the main theme of MEDICAL SOCIOLOGY are concerned with such topics as:

1. Health, disease, and deviant behavior.
2. Epidemiology and morbidity — the search for causes.
3. Contrasts in medical organization between the United States and Great Britain.
4. Institutional organizational factors which influence illness and patient care.

This excellent book is available on loan from the Public Health Library of the State Board of Health, Raleigh, North Carolina.

ANNUAL MEETING

N. C. Health Council, Inc.

Hotel Jack Tar — Durham

December 3, 1968 - 10 A.M. - 4 P.M.

In this annual meeting, the Council, composed of 65 State and area-wide organizations concerned with health, will give emphasis to the role of the voluntary health associations in North Carolina.

Edwin S. Preston, President

Raleigh's Medcenter

Your Health for Saturday 9:30 a.m. in WPTF (Raleigh). This is Edwin S. Preston. Our guest today is Mr. Alexander King, administrator of the Medcenter in Raleigh.

Q. What is a Medcenter?

A. A Medcenter is an Extended Care Facility. A modern medical facility providing excellent patient care. The entire Medcenter program is designed to offer the recuperative patient a service and environment that will promote early recovery.

Q. What services does the Medcenter provide?

A. The Medcenter provides quality care for patients who do not need all the services of a hospital but who do need specialized services for further recuperation.

Q. Where is Medcenter/Raleigh located?

A. Medcenter/Raleigh is located at 616 Wade Avenue in the heart of one of the Southeast's finest medical communities. Medcenter/Raleigh will work closely with all hospitals in Raleigh to facilitate the transfer of patients and Medical Records.

Q. What is the admission policy at Medcenter/Raleigh?

A. Each patient is admitted by his personal physician who will make the necessary arrangements. If assistance is needed in transferring the patient from the hospital, the Medcenter will provide transportation.

Q. How do the charges at the Medcenter compare with hospital charges?

A. The Medcenter charge for normal daily care may vary from time to time but usually will be about half of the hospital charges.

Cost of X-Ray—laboratory, physical therapy will approximate those of the hospital.

Q. Does the Medcenter provide for other needs of the patient?

A. An attractive lounge on each patient floor provides for patient activities such as visiting, reading, and games. There is also an Activities Center on the ground floor.

An Activities Director supervises recreational functions.

Q. What is the concept behind Medcenters?

A. The Medcenter offers a new concept in recuperative care. It is designed, equipped and staffed for the special needs of the convalescent patient.

The Medcenter patient will find a warm and pleasant facility, combining the finest technical skills with luxurious surroundings.

Medcenter/Raleigh is a nice place to get well.

Q. Describe a typical patient room.

A. All of the spacious rooms have full baths, wall-to-wall carpeting, colorful drapes and modern furnishings. Individual heating and cooling units in each room permit patients to maintain whatever temperature is most comfortable. Each room has telephone service and patient/nurse intercom. Black and white and color television is available.

Q. Does Medcenter/Raleigh have a Medical Staff?

A. Yes.

All applicants for membership on the Medical Staff shall be graduates of approved Medical Schools, legally licensed to practice medicine in the State of North Carolina and eligible for membership in the Wake County Medical Society.

Equivalent qualifications shall be

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required of dentists for appointment to the Medical Staff.

The active Medical Staff consists of physicians, residents in the community, who have been selected on the basis of individual character, competence, experience and judgment.

The courtesy Medical Staff—same qualifications as active Medical Staff

and they do have admitting privileges.

- Q. Is insurance coverage available now to cover costs in Medicenser?
- A. Each individual must contact his insurance carrier and ask about the coverage.
- Q. Is your facility eligible for Medicare reimbursement?
- A. Yes.

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Poliomyelitis Immunization Programs Should Continue

Poliomyelitis immunization programs for infants and children should be actively continued and special efforts made to reach segments of the population with low immunization rates, the Public Health Service Advisory Committee on Immunization Practices has recommended.

The committee pointed out that following the introduction of poliovirus vaccine in 1955, the number of paralytic poliomyelitis cases declined from 18,308 in 1954 to a low of 61 cases in 1965. The following year, however, there was an increase in paralytic cases. During 1966, a total of 108 cases were reported in the U. S. and Puerto Rico, most of them in unimmunized children less than 5 years of age in South Texas.

With This Issue

With this issue I am terminating my service as Editor of **The Health Bulletin** (for the past ten months, Guest Editor).

This has been an enjoyable task — one in which the many contributions of others are due the major credit for what may have been good in the results.

I Express My Gratitude

To State Health Director, Dr. Koomen (and Dr. Norton in earlier years), to Administrative Services Director, Ben Eaton (and Charlie Harper, earlier), to the members of the Editorial Board, to the State Board Staff, and especially to Mrs. Mary Howell, Public Relations Associate (and Mrs. Doris Sitterson, earlier), as well as to persons interested in public health in many places in North Carolina and elsewhere.

And I owe a heavy debt of appreciation to The Graphic Press of Raleigh, our printers,—To Mr. Braxton Flye and his able staff — appreciation for excellence and imagination in the printing — and even more for serving with much more than their expected share of help, understanding and forgiveness.

To those who carry on in these responsibilities, I would express my good wishes as they seek to produce a publication which presents subjects that are important in public health in ways that are interesting to the general public.

A handwritten signature in cursive script that reads "Edwin S. Preston". The signature is written in dark ink and has a long, sweeping underline that extends to the right.

Report From A Battlefield That Is Still Smoking

A special Task Force for Smoking and Health issued a report recommending steps to protect the health of the people against the hazards of cigarette smoking.

The Task Force was appointed by Surgeon General William H. Stewart in November, 1967, to consider further action that might be taken by Government, private agencies and individuals to "stem the rising tide of early deaths and disabilities associated with smoking."

In transmitting the report, Task Force Chairman Dr. Daniel Horn said, "We believe the health dangers are so serious and the programs to meet them

are, relatively, so inadequate that there is need for a vigorous acceleration in protective action."

Task Force recommendations called for stronger action by Government and private agencies in these priority areas: advertising and promotion; education of youth to prevent cigarette smoking; influence of health professionals on their clientele; use of group approaches to prevent or reduce smoking; and development of less hazardous cigarettes and ways of smoking.

Members of the Task Force, in addition to Dr. Horn, who is director of the Public Health Service's National Clearinghouse for Smoking and Health, were: Stephen Abrahamson, Ph. D., Director, Division of Research in Medical Education, University of Southern California.

George M. Beal, Ph. D., Professor of Rural Sociology, Iowa State University.

Emerson Foote, Member-at-large, National Interagency Council on Smoking and Health.

George James, M.D., Dean, Mount Sinai School of Medicine.

David A. Kindig, M.D., Ph. D., President, Student American Medical Association.

Jennelle Moorhead, Professor of Health Education, University of Oregon.

Jackie Robinson, Special Assistant to the Governor of New York for Community Affairs.

Leonard M. Schuman, M. D., Professor of Epidemiology, University of Minnesota.

Ernest L. Wynder, M.D., Associate Member, Sloan - Kettering Institute for Cancer Research.

An 11th member, Kimball Wiles, Ph. D., died in an automobile accident on February 1, 1968. He was Dean of the College of Education, University of Florida.

Take Care Of Your Feet

Man got aches and pains in his feet along with civilization. The 26 bones, 19 muscles and 100-odd ligaments in each foot weren't engineered to stand up under the beating of concrete pavements and hard floors.

As you grow older, your feet become more vulnerable to disorders. Most foot trouble usually stems from mistreatment—the wrong kind of shoes or wrong kind of care. Ill-fitting or foot-distorting shoes are the chief cause of foot problems. A tight shoe will cause friction and pressure. Corns or calluses may result.

The best way to cure ordinary foot troubles is to buy shoes that fit properly. Your shoes should be roomy across the toes, and fit snugly in the heel and through the "waist" of the foot. A hard toe cap can safeguard against stubbing injuries.

More life for your years, a fact sheet for older persons from the American Medical Association advises the following to avoid foot troubles:

- Wash your feet daily with warm (never hot) water and mild soap, drying thoroughly. If circulation is poor, hot water makes too much demand on the arteries to deliver blood when they cannot.
- Trim nails straight across to avoid ingrown toenails.
- When you're tired, rest with your feet up. Try lying for a half-hour or so with your feet higher than

your head, with pillows beneath your legs.

- Don't cut corns or calluses with razor blades, scissors, or similar implements.
- Beware of "remover" medicines containing salicylates. Harsh chemicals that eat through toughened skin can irritate normal tissues and cause infection.
- If there's a reddish or brownish discoloration around or on a corn or callus, seek medical attention.
- Change your shoes often to give them a chance to dry out.
- Exercise — wiggle your toes; rotate your feet in circles at the ankles; pick up marbles with your toes; walk barefoot on grass or sand, but not on hard floors.

Healthy feet make a healthier you. Sore or aching feet can cause fatigue and ruin your disposition. An examination of your feet should be a part of your regular yearly medical checkup, as some foot problems can arise before causing pain.

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Guest Ed.—Edwin S. Preston, M.A., LL.D.

Vol. 83 September, 1968 No. 9

Contraceptive

Drugs

For

Recent

Fertility

Studies

Men

Show Promise

May

Now

Be

Feasible

The promise of contraceptive drugs for men now appears feasible on the basis of male fertility studies in animals and humans described before the 11th National Medicinal Chemistry Symposium of the American Chemical Society.

Dr. Dolores J. Patanelli—reproduction physiologist of Rahway, N. J.—reported that successful control of male fertility with drugs has been achieved in laboratory animals, but that undesirable effects were observed in limited clinical studies, which have precluded further consideration of these drugs in man. Dr. Patanelli, who is with the

Merck Institute for Therapeutic Research, felt, however, that studies to date do suggest compounds will be found that will bring about desired effects without serious toxicity or side effects.

While unfruitful in drug products thus far, investigations, in her opinion she said, indicated that the most practical objective of male contraceptive drugs would be to interfere with the intricate process of sperm production (spermatogenesis).

She described spermatogenesis as a precisely synchronized process of cellular multiplication and differentiation, and as such is vulnerable to designed interference.

According to Dr. Patanelli, the drug studies have demonstrated that there are two possible chemical approaches to influencing fertility. One is a hormonal approach that prevents or inhibits spermatogenesis by interfering with the production of pituitary hormones. The other, a nonhormonal approach, may either inhibit sperm cell development or lead to cell destruction as at some stage of spermatogenesis, or interfere with cell function so that, although spermatogenesis is not inhibited, the ability of the sperm to fertilize the ovum or maintain the zygote (fertilized ovum) is lost.

Dr. Patanelli said several non-hormonal drugs are now being studied in her laboratory and others in an attempt to inhibit spermatogenesis without affecting endocrine functioning.

Studies thus far, she said, included the chemical family of nitrofurans, which while effective over long periods of time with a single dose, was too toxic to enter clinical trial.

Describing work with the hormonal approach, Dr. Patanelli said that estrogens and other components of the female "pill" have been demonstrated to

affect the hormone output of the pituitary gland so as to inhibit or prevent spermatogenesis.

The major shortcoming of this approach, according to Dr. Patanelli, has been the capacity of these drugs to block male hormones, thus affecting libido and potency. Androgenic hormones have been found less objectionable, but their high cost and need for frequent injections hindered research efforts for many years. Interest in these hormones had been renewed recently with the development of long-acting androgens, she said.

She explained that sperm undergo a "physiologic maturation" while in the epididymis and attain maximum fertilizing capacity and greatest ability for movement in the seminal fluid.

While many of the numerous substances making up the seminal fluid have yet to be identified, Dr. Patanelli said, studies have demonstrated that a factor present in the semen provides a protective outer coating for the sperm. This coating must be removed before the sperm can fertilize the ovum.

She said studies also showed that when sperm, in most animals and perhaps in man, reach the female genital tract, they undergo further physiological changes which endow them with the capacity of penetrating the egg (capacitation).

While the male approach is being pursued at a number of medical centers and by at least four major drug firms, Dr. Patanelli foresaw another problem, other than finding suitable drugs.

According to the Merck scientist, because some men associate fertility with virility, extensive education would be required to get men used to the idea of a male contraceptive when and if such agents were to become available.

Bat

Rabies

And

Human

Exposure

Rabies virus in bats was not recognized until 1953. Since that time the volume of research and publications on this subject has continued to increase, yet there remain many unanswered questions about the epidemiology of bat rabies; however, certain facts concerning bat rabies have been established and these must be considered when evaluating a human exposure to a bat bite.

Since January 1, 1968, there have been five bats confirmed as having rabies by the State Laboratory. During this time only twenty bats have been examined for rabies. From these figures, one should not conclude that 25% of the bat population in North Carolina is carrying rabies virus. Bats submitted to the Laboratory have been selected and thus do not reflect an accurate infection rate.

We have no accurate record from which to derive an infection rate of the bat population in North Carolina. If

we look at the population studies conducted in the Southwest, we see that the infection rate varies from 1 to 3%. During the spring, the time of migration back into an area, the infection rate is generally around 1% and by late summer the infection rate has generally increased to about 3%. These facts and figures probably hold true for this area and North Carolina.

All bats in North Carolina are classified as insectivorous bats due to their food habits. There are no vampire type bats in this area. Vampire bats are those that require a blood meal. Insectivorous bats normally do not attack man or animals. Their diet consists almost totally of insects—flying insects rather than crawling insects.

Most of the bats in North Carolina live together in bat colonies and frequently find shelter in abandoned houses, barns, tobacco barns, schoolhouses, churches and other buildings that are seldom used.

A bat colony may contain many thousands of animals or be fewer than one hundred. There are also several species of solitary bats in North Carolina. As the name implies, these bats live alone, usually in cracks and hollows of trees and crevices of rocks. The solitary bats are likewise insectivorous in nature and do not normally attack man or animals.

The bat's only defense is its ability to bite with needle-sharp teeth. Thus the expected reaction of a fallen or sick bat is to bite its offender, be it man or animal.

Are we currently experiencing an increase in bat rabies in North Carolina? In all probability there is not an increase in the infection rate of rabies in our bat population; however, the Veterinary Public Health Section has received a tremendous number of calls concerning human exposure and we have confirmed more cases in the

Laboratory than in the past several years. Publicity and the periodic regeneration of interest in bat rabies probably accounts for this apparent increase.

It is interesting to note that only five cases of human rabies, with bats as the source of infection, have been documented in the United States since 1953. Likewise, laboratory transmission studies from known rabid bats to domestic and wildlife animals have shown that bats do not readily transmit rabies virus; however, all bat bites should be considered dangerous and preventive measures should be taken.

When submitting bats to the State Laboratory, the intact animal should be submitted. This enables the Laboratory to examine the brain for rabies virus and also identify the species of bat. At the State Laboratory, only brain tissue is examined. This fact must be taken into consideration and laboratory results alone cannot be the determining factor in a decision to give post-exposure antirabic treatment.

It has been shown that rabies virus can localize in the salivary glands of a bat and not be present in the brain. When this occurs, such a bat may be excreting virus in its saliva for several months and yet show no outward signs of being infected with rabies virus.

A human exposure to such an animal would be a true exposure to rabies; however, such an animal would be laboratory-negative. The ideal solution to this dilemma would be to examine both the salivary glands and brain from each bat. The salivary glands of a bat are extremely small and frequently difficult to locate. Also, with such a small amount of tissue to work with, it would be unwise to interpret negative results as being valid.

For the above reasons, I think that every bat exposure, regardless of laboratory results, should be considered as a possible exposure to rabies virus and

preventive measures should be instituted accordingly. This is not to say that we should no longer examine bats in our laboratory for rabies.

It is important that we continue to examine these animals for two reasons. When a bat is found positive by laboratory procedures, this leaves no room for speculation as to the state of the animal. An established positive is more serious than an assumed positive. Also, surveillance is an important part of our total rabies control program in North Carolina. Surveillance serves to identify cases and keeps the general public aware of this potential health hazard.

There is little evidence to support the idea that rabid bats may be the source of a rabies epidemic in a community's dog population or surrounding wildlife. While this possibility is always present, perhaps the greatest public health hazard associated with bat rabies is individual exposure, particularly small children.

Bats should never be handled with unprotected hands, a fact most adults recognize. Small and inquisitive children may think a bat is a bird and attempt to pick it up. Such a mistake will most likely result in an exposure and any reference to the biting animal being a bird would warrant further investigation.

In summary, all human exposures (bite exposures) to bats should be considered as a possible exposure to rabies and preventive measures should be taken accordingly. While only five rabid bats have been confirmed this year, rabies in the bat population probably exists in every county in North Carolina. Since bats can be salivary gland positive and brain negative, laboratory results should not be the determining factor in a decision to administer post-exposure treatment.

**Veterinary Public Health Section
State Board of Health**

Motorcycles

Popularity

Accidents

Injury - Control

The current growth in motorcycling started in 1955 when the number of motorcycles registered in this country began to increase rather than decline. Since 1960, when a total of 574,080 motorcycles was registered, through 1965, when a total of 1,380,723 was registered, the annual increase in registration was almost double the increase of the previous year.

Deaths: In 1965 there were 1,515 deaths from motorcycle accidents, a rate of 0.8 deaths per 100,000 population. This is the highest recorded number of deaths for a single year. It is estimated that 2,000 deaths resulted from motorcycle accidents during 1966.

Death rates per 100,000 registered motorcycles are more than double the rates for other motor vehicles. Most of the deaths were males. The ratio of male to female is about 9 to 1. The highest death rates are found in three age groups: 15-19, 20-24, and 25-29. Collision with another motor vehicle is the most frequent type of accident (62%) followed by noncollision traffic accidents (32%) which include overturning and running off the roadway.

Injuries: It is estimated by the U. S. Public Health Services that 250,000

motorcyclists were injured during 1966. Accidents occurred most frequently at intersections in the daylight hours, on weekends, or dry level roads, and during summer months. Reckless driving, failure to yield right-of-way, following too closely, and excessive speed, by both motorcyclists and other vehicle drivers, contributed to the accidents.

One study in this country found that 20 percent of the injured persons were riding the motorcycle for the first or second time, while 70% had either rented or borrowed the motorcycle.

Glass Doors

The old joke about running into a door isn't so funny anymore now that glass doors have become part of American living. When people run into glass, the injuries can be a lot more serious than a black eye or a bump on the head. The injuries that occur are of the piercing-cutting variety, severe lacerations of the elbow, arm, wrist and hand being the most common. There are many cases of disfiguring facial cuts. The fatal injuries which occur generally result from severed arteries and uncontrollable hemorrhaging.

Safety glass is available and is actually being installed where new building codes require it. But, we're still faced with the millions of homes, shops and offices that are not so equipped.

We can make glass doors safer by decorating them with dividing bars, pressure tape, or decals. Remember that decals should be at two eye levels—one for adults and one for children.

Learn about tempered glass—laminated glass—wired glass.

A SEAT BELT
CAN WRINKLE
YOUR DRESS
A WINDSHIELD
CAN WRINKLE
YOUR FACE

National Safety Council

The

Way

They Did It

In 1918

Prosecutions were brought by the State Board of Health during the month of July against twenty physicians of the state for violations of the state quarantine laws. The laws with regard to the reporting of contagious and infectious diseases are very plain. Its language is such that it cannot be misunderstood by any intelligent person. It requires every physician to report such diseases that he attends promptly.

This duty is not a pleasant one but it is one which the State Board of Health has no intention of shirking. Every case of a violation of the quarantine laws will be prosecuted regardless of who may be affected. In doing this the State Board of Health is not only performing its manifest duty under the law but it is rendering North Carolina a safer place of residence for all the people. Prompt control of contagious and infectious diseases is possible only with a prompt knowledge of their occurrence. Such knowledge can be obtained only when the attending physicians make prompt reports as required by the law.

Bulletin of the North Carolina State Board of Health, September, 1918.

Causes

Of

Student Suicide

To Be Studied

Causes of student suicide will be discussed at a national conference in Washington, D. C., November 15-17.

Floyd D. Turner, co-director of the United States National Student Association and conference coordinator, said that specific suicide prevention methods and ways students and campus officials can prevent student crises and self-destructive behavior will be discussed.

Sponsored by the USNSA, the three day conference will be supported by a grant from the National Institute of Mental Health, according to Dr. Stanley F. Yolles, Institute Director.

Participating will be students, faculty members, deans of students, guidance counselors, campus health officials, psychiatrists, psychologists, sociologists, representatives from suicide prevention centers and representatives from professional and educational organizations interested in student suicide.

About 25 colleges will be represented. Reports on student suicide at each campus will be presented.

An Advisory Board of the USNSA will evaluate the conference and will direct the preparation of a report which will be distributed to conference participants and others, upon request.

Drug Abuse

**An interview with Dr. Roy J.
Blackley of the N. C. Depart-
ment of Mental Health.**

Radio Programs

Q. 1. Dr. Blackley, I understand that drug abuse, in general, means the use of drugs indiscriminately, too much and not as prescribed or recommended.

In general, what drugs are most abused?

A. Broadly speaking, these drugs may be divided into four broad categories. (1) Narcotics, (2) sedatives, (3) stimulants and (4) hallucinogens.

Q. 2. Could you tell me a little more about these drugs as you classified them? That is, would you give examples and effects?

A. I believe narcotics were mentioned first. These are the "hard drugs" Morphine and other opium derivatives as well as synthetic narcotics are examples. The appeal of morphine-like drugs lies in their ability to reduce sensitivity to both psychological and physical stimuli and to produce an

Radio programs like the one beginning in the right hand column have been carried over 50 radio stations in the State for the past year.

exaggerated sense of well being.

Some drugs such as paregoric, which is an extract of opium, are used for diarrhea and pain. Certain cough syrups containing codeine are narcotic-exempt preparations which are reasonably safe, but if not used properly can be abused.

Sedatives that are most commonly used and abused are the barbiturates. There are many kinds of barbiturates that have common every day names such as "goof balls", "red birds". They are prescribed by physicians for relieving tension, as a sleep producer, and as anticonvulsants. Chronic use and abuse of these drugs can cause psychological and physical dependence.

Stimulants, usually are amphetamines, the "pick-up" drugs that are used for mental depression, fatigue and weight reduction. There are various trade names for these.

The classes of drugs I have mentioned are easily abused and are dangerous if not taken under the direction of an ethical and competent physician. There are many contraindications to these drugs. They may cause undue complications in certain individuals. They should not be used when a person has certain diseases.

Hallucinogens are drugs that cause distortions of perceptions, dream images and hallucinations. They are also known as psychotomimetics or psychodelics. The ones commonly known are L.S.D. (or d-hysergic acid diethylamide) and D.M.T. (or dimethyltryptamine) and have no medical use except in research.

Marihuana is another drug in this category. There is no proof that it causes dependency or causes withdrawal symptoms.

Solvents, such as glue, gasoline, paint thinner, etc. will produce intoxication and possible death. Repeated use indicates a development of dependency.

Q. Dr. Blackley, would you advise us or give some suggestions for drug abuse prevention?

A. There are several rules that may be followed. I believe that an honest approach concerning the dangers of this problem is basic. Prevention must be started early and continued through public education—in schools and all mass media—newspapers, books, radio and T.V.

Facts should be given.

In-service education, seminars and other organized meetings at all levels should be used to inform teachers, parents and the general public about the numerous phases of drug abuse problems. Film and literature are available.

Possible illicit drug sources should be reported and investigated by proper authorities.

Law enforcement authorities should have regular meetings regarding drug abuse.

I might add that the combination of many drugs and alcohol is most dangerous. Some drugs will increase the effect of alcohol. An example would be that one drink of alcohol and a tranquilizer might double the effect of alcohol. You can see how dangerous this might be when driving. A breathalyzer test may show that a person's alcohol blood level is below the legal level of driving under the influence and yet he might be just as intoxicated.

Q. Is there any help for persons who are in trouble with drugs?

A. Yes, help and information can be obtained through physicians and local governmental health facilities. The type help depends on early recognition, type of drug and many psychological and social factors that are often involved with this huge problem. Rehabilitation programs are available for those who want help.

Drug abusers can be helped.

New Encyclopedia Of Chemicals And Drugs

The Merck Index, an encyclopedia of chemicals and drugs first published in 1889, is being published in a new Eighth Edition by Merck & Co., Inc., Rahway, N. J. The Seventh Edition was published in 1960.

The new edition, prepared by a staff headed by Paul G. Stecher, offers descriptive monographs of more than 9,500 chemicals and drugs arranged alphabetically by generic or non-proprietary name, and contains 2,000 new entities. They are illustrated by nearly 5,000 chemical structure diagrams. More than 4,800 of the monographs contain information on medical uses and toxicities of the substances.

The Cross Index of Names, containing 42,000 entries, enables the reader to locate chemical descriptions by chemical, generic or proprietary name.

New in the Eighth Edition is the Chemical Formula Index which precedes the Cross Index of Names, providing another key to the monographs. Other new and different features include: abbreviations of non-proprietary names adopted by USAN and WHO for organic radicals, prefixes used in the metric system, code letters used by various companies for experimental compounds, an indexed Table of Contents, and an "Explanatory Notes & Key to Monographs."

The Merck Index, Eighth Edition, printed on English finish paper and bound in a gold-lettered, maroon 'Sturdite' binding, may be ordered directly from technical book dealers or from Merck & Co., Inc., Publications Dept., Rahway, N. J. 07065.

Getting Ready For Next Summer

Those extra pounds you put on during the winter will be showing in your next summer's light-weight clothes, says the N. C. Heart Association.

Bathing suits and sports wear demand slim, trim figures as all the clothing designers tell you, but the slim, trim figure could mean more to you than high fashion on vacation. It may mean years of longer life. To get the figure back in shape there are two rules to follow.

First, push yourself away from the table. No one ever lost weight by feasting, and a sensible moderate diet with an eye on the calorie intake will go far in losing those extra unwanted inches. The North Carolina Heart Association reminds everyone to avoid fad diets. While losing weight, always maintain a well-balanced diet. There is no quick and healthy way to lose weight, but by watching the intake of calories and increasing the level of your physical exercise, weight can be lost.

The second road to a trim figure is exercise. Here again the North Carolina Heart Association reminds you that, like eating, exercise should be done in moderation. Develop your level of exertion slowly. If you have a history of heart disease, by all means, check with your physician before attempting any unusual exercise or exertion. Muscles tone slowly, but through day by day effort you can reduce unwanted fat and increase the overall muscle tone of your body. Remember obesity is never popular and can be dangerous. If you are 20 percent over your ideal weight, then you are obese.

Lose weight, tone the muscles and you'll feel better, you'll look better, and you may live longer.

New Federal Program Treats Drug Addicts

As of a mid-year report, over 450 narcotic addicts have been committed for examination or treatment under a new Federal program described in a flyer now available from the Public Information Branch, National Institute of Mental Health, Health Services and Mental Health Administration.

Entitled "The Narcotic Addict Rehabilitation Act of 1966—A New National Policy," the flyer outlines the provisions of a **total** treatment program that views narcotic addiction as an illness rather than a crime.

The law provides for the civil com-

mitment of addicts, including those charged with or convicted of violating certain Federal criminal laws as well as others not charged with an offense. Addicts who have committed a crime of violence are ineligible.

For the first time the Federal government is assuming the responsibility for aftercare services, which are to be developed in the addict's home community. The NIMH is also administering a grant support program authorized by this Act for States, local governments and organizations to develop community treatment and rehabilitation facilities.

NIMH field offices in New York, Chicago, and Los Angeles are already in operation, providing consultation to local planners and negotiating and monitoring contracts for providing aftercare. Offices will be established in the near future in many other cities where there is a high incidence of narcotic addiction.

The NIMH is responsible for the administration of all aspects of the NARA program except those pertaining to the treatment of convicted criminals. This phase of the program is administered by the Office of the Attorney General in cooperation with the NIMH.

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North Carolinians

Working On

Heart Research

Grants

Eight North Carolina scientists have been named by the American Heart Association to receive research grants during this fiscal year, according to Dr. James A. McFarland, President of the North Carolina Heart Association.

The newly announced Grants-in-Aid awards are part of a record \$12,000,000 research effort being underwritten by the American Heart Association and its affiliates for the 1968-69 fiscal period, Dr. McFarland said. The Association's research program is supported

by public contributions to the Heart Fund campaign in February.

Of the \$12,000,000 total, approximately \$5,000,000 represents allocations made this year by the Association's national Research Committee. The \$7,000,000 balance will be expended by state and local Heart Associations for their own research programs.

"Since 1949 when the Heart Association made its first grants, about 140 million Heart Fund dollars have been channeled into cardiovascular research," Dr. McFarland pointed out. He continued:

"Over the years, with ever-increasing public contributions of Heart Fund dollars, our most gifted research scientists have been enabled to search for answers to the complicated problems of the heart and circulatory diseases.

Following are grants made in North Carolina by the American Heart Association: Dr. Carl Gottschalk of UNC; Dr. Peter Halloway, Dr. Frans Jobsis, Dr. Bettie Masters, Dr. Klaus Brendel, and Dr. James Clapp of Duke; Dr. Margaret Conrad and Dr. Robert Bond of Bowman Gray Schools of Medicine.

ANNUAL MEETING

N. C. Health Council, Inc.

Hotel Jack Tar — Durham

December 3, 1968 - 10 A.M. - 4 P.M.

In this annual meeting, the Council, composed of 65 State and area-wide organizations concerned with health, will give emphasis to the role of the voluntary health associations in North Carolina.

Edwin S. Preston, President

THE HEALTH BULLETIN
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Nursing Home Seminar Approved For March

Chairman William T. Herzog, UNC School of Public Health, informed the Advisory Committee for Nursing Home Seminar that \$2,000 in funds had been approved by the Governor's Council on Aging for the proposed executive course next spring. The Committee approved March 24 through 28 as the dates for the course which would be conducted in Chapel Hill.

Additional funds will be requested from the Public Health Service, Herzog advised. The \$2,000 grant from the Governor's Council would provide tuition costs for forty students but could not be used for their living expenses at the course. It is planned to conduct another course in the fall of 1969 for those who cannot attend the March course.

Fluoridation Legislation State-wide In Minnesota

Thousands of Minnesota children will enjoy less tooth decay in their growing-up years as a result of the State legislature's passage of a state-wide water fluoridation law affecting all municipal water systems.

Hailed as a landmark contribution to dental health by Dr. Viron L. Diefenbach, Assistant Surgeon General and director, Division of Dental Health, Public Health Service, the act calls for fluoridation of all municipal water supplies within the State of Minnesota by January 1, 1970. More than 500 communities will be affected by the new law.

Minnesota is the second State to adopt a measure authorizing fluoridation of all municipally-supplied water. Connecticut passed a similar measure in 1965, but that law covers only those communities with 20,000 population or over.



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December 1968



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GOVERNOR MOORE PRESENTS
HUMANITARIAN AWARD

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Vol. 83 October 1968 No. 10

Cover: Fannie King of Jacksonville is first North Carolinian to receive Humanitarian Award for saving a life. Governor Moore made the presentation.

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Humanitarian Award



HAPPY OCCASION — The Governor's office in the State Capitol was the scene as Mrs. King received her award. Sharing the moment are (left to right) Elmer King, Vance Kee, Mrs. King, Gail King, Governor Moore.

Jacksonville Woman Is First Tar Heel to Win National Award

Less than three weeks after completing a course in medical self-help training, Fannie W. King of Jacksonville used the knowledge she had gained to save the life of a teenaged boy, following a surfing accident at Topsail Island.

A year later, Mrs. King became the first North Carolinian—and the seventh American—ever to win the Medical Self-Help Humanitarian Award of the United States Public Health Service and Office of Civil Defense.

Governor Dan K. Moore presented the award to Mrs. King at ceremonies at his office in the State Capitol on September 6.

Mrs. King, wife of Elmer King, is the mother of two teen-aged daughters. She is also a licensed practical nurse, employed by Onslow Memorial Hospital in Jacksonville.

She completed her course in medical self-help training on July 10, 1967. Nineteen days later—on July 29—she performed an act of heroism that saved the life of a fellow human.

Mrs. King and her daughter Gail had gone to the family's cottage at Surf City, on Topsail Island, just off the North Carolina coast.

White-Capped Water

It was a hot, windy Saturday. The water was white-capped. Surfers were having trouble in the water.

At noon two teenaged couples dropped by the cottage for sandwiches and sodas. They had been trying to ride the waves on surfboards. One of the boys was William Randall (Randy) Koonce, 16, a neighbor of the Kings in Jacksonville.

Mrs. King fed the youths and urged them not to return to the water. The ocean was too rough, she thought. But the teenagers went on.

Two hours later Mrs. King, alone in the cottage, relaxing with a book, was startled by a scream from her daughter. She rushed to the door.

"Mama, Randy is about drowned!"

"Where?"

"In the back seat of the car."

Later Mrs. King said she thought for a moment that her daughter was "pulling her leg."

She rushed to the car parked out front. There she found Randy Koonce—on the back seat.

"He was covered with sand, extremely cyanotic [blue] around the mouth and eyes, completely limp, cold to the touch, and not breathing." Thus Mrs. King remembers Koonce's condition.

Only Adult

The boy's companions were crying and sobbing. Mrs. King was the only adult around.

"Take my car and go for help," she told her daughter.

She looked again at young Koonce. Oxygen, immediately, she decided.

She pulled the limp body across the seat of the car far enough for the head to hang off the seat, slightly backward, chest facing up.

She cleared the victim's throat with her finger, grasped his chin in her right hand with her thumb inside his mouth,

pressed his nostrils together with her left hand, covered his mouth with her own—and began to blow.

Afterwards, Mrs. King said she gave only passing thought to the “gunky” mucus covering the patient’s nose, upper lip and mouth.

Applying mouth-to-mouth resuscitation, she forced air into the youth’s lungs at the rate of 12 breaths a minute.

There was a gag reflex. She turned his head to the side. But nothing happened.

A few more puffs into his lungs—and another gag. Then another. And another.

She pulled the boy out of the car and onto the ground. He was still cyanotic, still not breathing.

She continued mouth-to-mouth resuscitation. He gagged again. This time when she turned him to the side, he vomited, a thick, amber-colored fluid. He gasped for breath.

She administered more mouth-to-mouth resuscitation—ten seconds, thirty, a minute.

Suddenly Koonce began to breathe on his own — short, gaspy breaths, without rhythm.

Neighbor's Oxygen

By now a crowd of onlookers had gathered. One, a beach neighbor, had brought a portable oxygen tank and face mask.

Mrs. King took it. She broke the seal and administered the oxygen—two minute doses, broken by 30-second intervals.

The ten-minute supply of oxygen was exhausted. Now Koonce’s respiration was rhythmic, 36 a minute. His pulse rate was 140. Cyanosis had diminished to a minimal point.

Three men from the gathering of onlookers helped Mrs. King move young Koonce out of the hot sunshine and into the cottage. She placed him in shock position.

In a few minutes he opened his eyes and spoke.

“What, I don’t remember,” said Mrs. King later. “By this time I had a terrific headache and was getting nervous.”

But by this time, Mrs. King had saved a life.

A beach patrolman arrived and took Koonce to a doctor in the nearby town of Burgaw.

Seemed Like Hours

Looking back, Mrs. King says she has no idea how long the mouth - to - mouth resuscitation procedure took. “Probably it was three to five minutes, but it seemed like hours.”

However, one of the onlookers, H. B. Hodnett of Raleigh, says that he arrived on the scene after Mrs. King had started mouth-to-mouth resuscitation, and even then she worked

over the victim five to eight minutes before administering the oxygen.

What had happened to Randy Koonce before Mrs. King was startled by the scream from her daughter?

Despite the rough seas, Koonce had gone back into the water with his surfboard.

Shortly afterward, a companion, Kenneth Edward Hill, 17, of Charleston, S. C., looked up from the beach and saw Koonce's surfboard floating free in the water. Then he spotted Koonce more than 200 yards out, fighting to stay afloat.

Hill plunged into the water and swam out to help. But when he reached Koonce, he encountered a nearly drowned victim who was almost hysterical in his struggle against the undertow.

Koonce lost consciousness before Hill could make any headway toward shore.

When Hill was finally able to get Koonce onto the beach, one of the other youths tried an arm-pulling, chest-pumping maneuver. Koonce vomited. But that was all.

On His Back

Koonce's friends put him on a surfboard *on his back* and carried him over the sand dunes to their car.

By this time Gail King had



Randy Koonce

arrived on the scene and learned what had happened.

"Take him to my mother," she said. "She will know what to do."

The medical diagnosis of Koonce's injuries gave practi-

cally no clue to the actions of Mrs. King or Kenneth Hill. It read: "Concussion caused by hitting him on the head, with no ill effects of near drowning."

The Humanitarian Award won by Mrs. King is given to an individual who saves a person's life using knowledge gained from medical self-help training. It consists of an inscribed sterling silver medal, a sterling silver emblem to wear on her dress, and a certificate signed by officials of the awarding agencies.

Medical self-help training goes beyond the ordinary first-aid course. First-aid training teaches what to do until a doctor arrives. Medical self-help training teaches life-saving techniques to use when a doctor is not available.

More than 100,000 Tar Heels have taken medical self-help training since it was first offered in 1962 by the State Board of Health and the North Carolina Civil Defense Agency.

Mrs. King took the course while she was a student in the practical nurse education program at Onslow Technical Institute. Her teacher was Vance Kee, director of the Jacksonville - Onslow Civil Defense Agency.

Randy is the son of Mr. and Mrs. W. T. Koonce of Jacksonville.

Measles Shutout

Not a single case of measles was reported to the State Board of Health in September. It was the first month in which no cases turned up in North Carolina since measles became a reportable disease in 1913.

For the "epidemic year" running from October 1, 1967 through September 30, 1968, a total of 363 cases of measles was reported to the State Board of Health—a decrease of 70 per cent from the preceding epidemic year, when 1,212 cases were reported.

The sharp drop in reported cases is due mainly to immunization. The State Board of Health distributed 220,000 doses of live measles virus vaccine to local health departments and private physicians throughout North Carolina over the past 30 months. In addition, physicians gave the vaccine privately.

Because of the low incidence of measles, officials at the State Board of Health now propose to investigate each case of the disease reported.

The Local Health Department: What Is It?

By Barbara Kahn

Health Education Consultant

North Carolina State Board of Health

Wherever you live in North Carolina, there is a local health department to serve your needs. It may be a county department, or it may be a district department serving more than one county.

Local health departments throughout our State carry out programs and offer services designed to promote and protect the public health of all North Carolinians.

The community is the health department's "patient." Conversely, the health department is the community's "doctor."

The effectiveness of many activities of your local health department is measured not by what happens, but by what does

not happen. Many activities are aimed at preventing health problems.

For its "patient"—the community—the local health department collects facts, makes the diagnosis, then sees that treatment is applied. It keeps track of health problems—where they occur and with what severity. It keeps tabs on the leading causes of death. And it stands ready to commit its resources to solve any problem that may come up.

Individual Meaning

What are some of the services provided by local health departments? And what meaning do

they have for you, as an individual North Carolinian?

Safe Water . . .

A constant surveillance of your water supply and sewerage system to be sure they are safe is one—if you live in the city. If you live in the country, health department officials are prepared to give free advice regarding a safe well and sanitary septic facilities.

Sanitarians from your health department work with restaurant owners and workers to make sure the food you eat there is safe. If it is not, either the unsanitary conditions must be corrected or the restaurant must close. The same thing goes for grocery stores, meat and seafood markets, food processing plants, shellfish harvesters and packers and other food handling businesses.

Advice and assistance regarding the elimination of insects and rodents are available from the sanitarian.

In schools, the rest rooms, drinking fountains and kitchens are checked for sanitation.

When communicable diseases such as dysentery and hepatitis are reported, the public health physician, nurses and sanitarians work together to find and eliminate the source, and thus prevent further spread.

X-rays, skin tests and clinics for physical examinations are provided for detecting tuberculosis. Help in getting proper treatment is available for those who contract the disease.

Public health workers find and treat venereal diseases not cared for by private physicians.

Birth Certificates

The health department keeps track of all births and provides birth certificates. Many departments provide clinics for expectant mothers and for regular check-ups of infants and pre-schoolers. All departments provide clinics for immunization against smallpox, polio, diphtheria, whooping cough and tetanus.

If you are going to travel abroad, you can receive whatever shots are required at your local health department.

Special clinics are provided within easy traveling distance for children from birth to age 21 who have crippling conditions, cystic fibrosis, burn scars, rheumatic and other heart conditions, birth defects, and other handicaps.

There are clinics for persons suffering seizures, others to determine the condition of children who seem to be mentally retarded.

Eye clinics for children are held in many health departments in cooperation with the Commission for the Blind.

Some local health departments provide tests to discover diabetes and glaucoma. When these diseases are discovered early enough, your doctor can help you keep them under control.

Dental inspections of school-age children are provided. Some corrective work is done for children whose parents are unable to pay for private care.

Nurses Counsel

Public health nurses—the girls in blue—make home visits to help families learn how to carry out their doctors' orders. They counsel the family about nutrition and child growth and development.

Some departments have accredited Home Health Agencies, in which nurses, and sometimes physical therapists, give personal care to persons ill at home. Medicare patients in particular enjoy these services. Public health nurses also know about community and state health resources, and can help a family obtain the aid it needs.

Health information is an important service of the health department. Organizations may

obtain speakers, films, and pamphlets on health topics, as well as help in planning programs of significance.

Your local health department is backed up by the State Board of Health, which employs specialized health personnel to serve as consultants.

The health department, however, is just one health resource in your community. Others are private physicians and dentists, hospitals, nursing homes, mental health centers, and vocational rehabilitation and voluntary health agencies. The welfare department provides funds for some health services, as do schools.

One big task facing local health departments and the State Board of Health is planning the most efficient and effective use of all resources. New problems emerging with rapid changes all around us require concentrated attention: automobile accidents, suicides and homicides, air pollution, chronic illnesses and others. The ideas, reactions and expressions of the public are needed.

You can help your health department. Go by for a visit one day soon. Talk over local problems with the health director or a member of the staff. The welcome mat is always out for concerned, alert citizens.

State Board of Health Holds Quarterly Meet

The North Carolina State Board of Health met September 19 at Canton and adopted rules and regulations which for the first time set sanitation standards for local confinement facilities throughout the State.

The board also took action to make population density a factor in protecting watersheds from overcrowded septic facilities, and to protect both restaurant operators and the public from contaminated shellfish.

The new regulations for confinement facilities will go into effect next January 1. They call for inspection and scoring of such items as cleanliness, lighting, ventilation, water supply, laboratory facilities, bedding, diet, and methods of preparing, handling, storing, protecting and serving food.

The Board acted under a law enacted by the 1967 General Assembly. The statute gives enforcement authority to the State Department of Public Welfare, but directs the State Board of Health to adopt rules and regulations governing sanitation.

Inspection will be carried out by sanitarians of local or district health departments at least once a year. Additional sanitation inspections will occur when inspectors from Public Welfare spot hazards or deficiencies.

Sanitation inspectors will not award a numerical grade to confinement facilities, as they do for restaurants, meat markets and other food handling establishments.

Instead, they will award demerit points, the type and total of which will determine if the confinement facility is classified as approved, provisional or disapproved.

The commissioner of Public Welfare has authority to order a disapproved facility closed.

J. M. Jarrett, director of the sanitary engineering division at the Board of Health, said the new inspection program probably will not involve any additional personnel.

The revision of watershed regulations adds a requirement that on watersheds where soil conditions warrant it, residen-

tial lots for homes with individual septic tank facilities shall be at least 40,000 square feet in size.

A change in sanitation regulations for restaurants makes it mandatory for operators to keep shellfish in the containers in which they are shipped. Shippers label containers with an identification mark, Jarrett explained. In the event of an outbreak of illness due to contaminated foods, the source can be more easily traced, he said.

The storing requirement for

shellfish already is a part of regulations pertaining to markets and grocery stores.

In other action, the Board of Health approved the creation of a new Southwest Jacksonville Sanitation District and expansions of the Kannapolis and Haw River districts. Residents of the affected areas had petitioned for the action.

The Board also approved a general revision of regulations governing control of communicable diseases to bring them up to date.

New Appointments at State Board of Health

Dr. J. N. MacCormack, *consultant, Communicable Disease Control.*

Benjamin S. Shepard Jr., *coordinator of emergency medical services.*

David C. Corkey, *biostatistician, Public Health Statistics.*

Dr. Ruth Burroughs, *pediatric consultant, Personal Health Division.*

Dr. Verna Y. Barefoot, *public health physician, Personal Health Division.*

Etra Page Wood, *health educator, community health affairs, Raleigh regional office.*

Elizabeth G. Moore, *consultant in social work, Maternal and*

Child Health.

Dr. Buford J. Suffridge, *field dentist, Catawba, Lincoln and Alexander Counties.*

Dr. James Thomas Jumper, *field dentist, Pitt County.*

Dr. Phillip Guest Hathcote, *field dentist, Martin and Bertie Counties.*

Dr. Jerry W. Duncan, *field dentist, Randolph County.*

C. T. Clayton, *sanitary engineering technician, Western Regional Office, Asheville.*

Donald R. Butler, *sanitary engineering technician, Raleigh.*

Charlie T. Vann, *sanitary engineering technician, Asheboro Regional office.*

Patient Expenses Under Medicare

Going Up



Hospital and nursing home patients under medicare face a ten per cent increase in the expenses they must bear starting next January 1.

Robert A. Flynn, social security district manager in Raleigh, said the new schedule of expenses means that patients who now pay the first \$40 of hospital care costs will have to pay \$44.

The increase also applies to patient expenses for hospital stays of more than 60 days, and for stays of more than 20 days in extended care facilities.

A patient now pays \$10 a day from the 61st through 90th days of hospitalization. This expense will go up to \$11 a day.

A patient now pays \$5 a day for the 20th to 100th days of a stay in a post-hospital extended care facility. This amount will go up to \$5.50 a day.

For each day of the reserve account a person can draw from if he ever needs more than 90 days of hospital care, the patient cost is now \$20. This amount will increase to \$22.

Flynn explained that the increases result from a requirement of the medicare law that an annual review be made of the deductible amount. The first review was directed for 1968.

If the annual review shows that hospital costs have changed significantly, the hospital deductible amount for medicare must be adjusted for the year following the review. To avoid small changes, the increases must be made in \$4 steps, the law directs.

Flynn said a comparison of hospital costs in 1966 with those in 1967, using the formula in the law, worked out to an increase of \$45.36. Rounded to the nearest multiple of \$4 produces a deductible amount of \$44 for 1969.

Flynn pointed out that the changes apply only to the hospital insurance part of medicare. They do not affect the financing of voluntary supplementary medical insurance programs which cover doctor bills and a wide variety of other medical services.

How It Was in the Old North State

"And I understand the national and state governments are at our service if a hog has cholera. Is not the health of the average citizen of the town and county of as much value as a bull yearling? Why not get a health officer who is an expert on sanitation. Give him authority and let him be such a man as will enforce his regulations. If every person in Edgecombe was taxed ten cents—hang the expense, make it a quarter—such a person, with an assistant, could be procured."

—*Bulletin of the North Carolina State Board of Health, May 1916.*

New Health Directors In North Carolina

Alton Brown

Davie-Wilkes-Yadkin District

Michael Dechman

Jackson - Macon - Swain District

Carl Tuttle

Alleghany - Ashe - Watauga District

Dr. J. T. Barnes

Randolph County

Herbert Hawley

Rowan County

Dr. Joseph C. Knox

New Hanover County

Dr. Barbara Wood

Madison County

Your Driver's License Could Save Your Life

Ever look at the back of your North Carolina driver's license?

What you see there could save your life one day.

Or it could cost you your life.

North Carolina is the only state in the nation that provides a medical information questionnaire on its driver's license. But the forward-looking innovation is ignored by most people.

The blank calls for information on the driver's blood type (group and RH), date of tetanus immunization, whether toxoid or anti-toxin, medications, allergies, and other subjects.

If the blank is filled in, vital information is immediately available in the event of need to policemen, ambulance attendants, hospital emergency room workers, and doctors.

A campaign is now being conducted by several State agencies

and private institutions to educate Tar Heel motorists to see their family doctor and fill in the medical information questionnaire.

Sponsors of the educational campaign are The N. C. Department of Motor Vehicles, the Trauma Committee and the auxiliary of the Medical Society of the State, the N. C. Hospital Association, the N. C. Committee on Patient Care of North Carolina Blue Cross and Blue Shield, Inc.

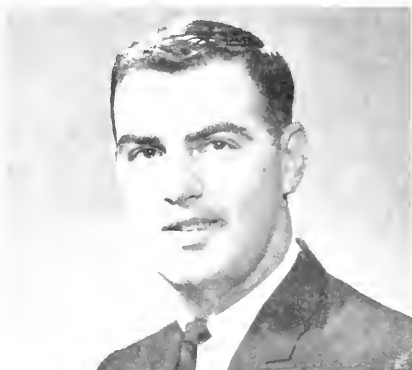
FAMILY HEALTH WEEK

President Johnson has proclaimed the week of November 17-23 as National Family Health Week.

The proclamation sets aside the week "as a means of focusing national attention during the year upon the accomplishments of the American health care system and the central role played by the family physician in the maintenance of superior medical care for Americans of all ages and from all walks of life."

Senator Ernest Gruening of Alaska and Representative Tim Lee Carter of Kentucky introduced the joint House-Senate resolution calling on the President to make the proclamation. Both Gruening and Carter are physicians.

NEW PLANNING OFFICER FOR HEALTH AGENCY



Gene Barrett of Cary has taken up duties as planning officer for the State Board of Health. He is the first man to hold the newly created position.

Barrett will coordinate the work of various divisions and sections on related programs to prevent duplication of efforts, and he will work to develop ways of making health programs more effective throughout the State.

Barrett is a native of Cleveland County. He is a graduate of Thomasville high school and North Carolina State University. He earned a degree of master of science in public health from the University of North Carolina at Chapel Hill.

He has held previous positions as statistical analyst, community services consultant, and administrative officer with the Board of Health and the Department of Mental Health.

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North Carolina Oysters, Clams, Crabs ... As Safe As They Are Good

The North Carolina Shellfish Sanitation Control program has received a near-perfect rating from the U. S. Public Health Service.

The program is administered by the State Board of Health and the Division of Commercial and Sports Fisheries of the Department of Conservation and Development to safeguard consumers from oysters, clams and crabs that might be contaminated.

The program earned a 97.2 per cent rating for 1968. It was the fifth consecutive year in which a higher rating was achieved than in the preceding year. The 1963 rating was 85.9

per cent.

The Board of Health maintains a permanent laboratory at Morehead City and a mobile lab for determining pollution.

Last year health workers analyzed nearly 5,000 water samples for bacteriological content and 18 samples of shellfish meat for sanitary quality.

Operators of shellfish harvest boats and processing plants cooperate in the program. Some 2,400 shellfish harvesters are licensed in North Carolina.

The Public Health Service evaluation also cited Tar Heel shellfish processing plants for their "exceptionally high quality of sanitation."



THE DEATH MAGAZINE

Vol. 83, No. 11

November 1968

ROMAN GABRIEL: SYMBOL OF
GOOD HEALTH AND PHYSICAL FITNESS

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THE HEALTH BULLETIN

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Editor: H. B. Rogers

Vol. 83 November 1968 No. 11

Cover: Roman Gabriel, quarterback for the Los Angeles Rams football team and former All-America at North Carolina State University, calls signals for the 1968 Christmas Seal campaign in the State.

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The New Influenza and the Old

A REPORT ON HONG KONG FLU

By. Dr. J. N. MacCormack

Consultant, Communicable Disease Control
North Carolina State Board of Health

Some old timers still call it "the grippe." Most people call it simply "the flu."

Regardless of what you call it, influenza has been with us for centuries. An epidemic in 1557 was described as follows:

It began with a roughness of the jaws, small cough, then a strong fever, with a pain of the head, back and legs; some felt as though they were over the breast and had a weight at the stomach; all which continued to the third day at the farthest; there the fever went off with a sweat or bleeding at the nose. In some few, it turned to pleurisy, or fatal peri pneumonia.

This classic description of the disease tells us that a flu epidemic 400 years ago was very

much like an epidemic today. A lot of people got sick—but few died.

Usually 15 to 40 per cent of the population is affected during an epidemic of influenza. Most deaths result from lung complications. These occur mainly in the elderly and among those with chronic respiratory or heart diseases.

After a person is exposed to the disease, it takes one to three days for symptoms to appear. Therefore, an epidemic of the flu can develop rapidly.

During an epidemic the highest attack rates are among the young. The rate of infection decreases with increasing age. This phenomenon points up the

fact that as a person grows older, he builds up a battery of antibodies against influenza viruses.

Significant Milestone

Medical men first realized that influenza is caused by a virus in the 1930s. It was a significant milestone.

The first influenza virus isolated from man was designated Type A. Epidemics in the United States caused by this virus occurred at two-year intervals in the 1930s and at three-year intervals during the 1940s.

The Type B influenza virus was first identified in 1940. It has accounted for less extensive and generally less severe flu epidemics at four to six-year intervals since that time.

A significant variation of the A virus was first noted in 1947. This is known as the A1 or A-prime virus.

Yet another variation of the Type A virus appeared in 1957 when the A1 virus underwent a change and became the A2 virus. We called it the "Asian" flu virus.

Epidemics caused by variants of the Type A virus occur in the same two-to-three year intervals as those caused by the original Type A organism.

A Type C virus isolated in 1950 has proved to be of little importance.

The last A2 epidemic in the

United States occurred last winter (1967-68), and there was widespread involvement in most of the eastern states. Type B influenza caused an epidemic in 1965-66 in the eastern United States and in 1966-67 in the West. Based on these facts, along with a knowledge of the intervals at which influenza outbreaks occur, the United States Public Health Service Influenza Advisory Committee recommended last June that flu vaccine be administered this year only to high risk groups—the elderly and those with chronic diseases.

Virus Changes

Influenza vaccines, unlike many other vaccines, must be continually re-evaluated and re-formulated from year to year because of frequent changes in the characteristics of influenza viruses.

The bivalent vaccine—vaccine containing two types of influenza virus—recommended for use by the United States Public Health Service committee this year was prepared from two strains of Type A2 influenza virus isolated in 1962 and 1964 and one strain of Type B virus isolated in 1966.

A polyvalent vaccine is also available. It contains all four common types of influenza virus (A, A1, A2, and B).

The bivalent vaccine is rec-

ommended over the polyvalent type because it contains a higher proportion of the more recent strains.

Last July and August an influenza epidemic struck the Hong Kong area. Numerous cases of a clinically mild type of influenza were noted during this period. Mortality from complications was reportedly low.

This form of influenza subsequently spread rather rapidly both east and west of Hong Kong. Isolated outbreaks occurred among American military personnel returning from these areas. Civilian outbreaks were confirmed in several states, including North Carolina. A group of over 300 General Electric employees from North Carolina took a two week trip to Hawaii in September. A significant number of this group suffered a flu-like illness. The first cases developed shortly before leaving Hawaii for home.

Cases Confirmed

Soon afterward a contingent of 155 Shriners from North Carolina flew to Las Vegas and then on to Honolulu for a five-day excursion. Three members of this group were ill with flu before leaving North Carolina on October 13. By October 30 fifty-four more cases had occurred. Blood tests on people in this group confirmed Hong Kong flu.

The Hong Kong virus was classified by the World Influenza Centre of the World Health Organization in London as a variant of Type A2 influenza virus. The strain is so markedly different from preceding A2 viruses that some virologists have advocated that it be classified as a new type of influenza virus altogether: A3.

In any case, it is doubtful that currently available bivalent or polyvalent influenza vaccines will confer significant protection against this new strain. However, the June recommendations of the United States Public Health Service still will stand since infections from older strains of A2 and B virus still can occur. If history repeats itself, we are one year overdue for a widespread epidemic of influenza. Such pandemics have occurred in the past at ten-year intervals. The A1 type of influenza virus first appeared in 1947 and the A2 type made its appearance in 1957.

Vaccine Race

Seven American drug companies were issued a seed strain of the Hong Kong virus in mid-September so that they might begin the race against time to produce a new vaccine that will be effective against Hong Kong flu. The companies working on the vaccine: Lederle, Lilly, Merck, National Drug, Parke-

Davis, Pfizer, and Wyeth. Small supplies of the vaccine had been made available to North Carolina physicians in the last week of November; more was expected later, but demand will no doubt far exceed supply.

Since the initial supplies of vaccine are in rather short supply, the United States Public Health Service is recommending that those over 65 years of age and those of all ages with chronic debilitating diseases be given the vaccine first. The protection afforded by this monovalent vaccine has, of course, not been substantiated, but judging from experience with previous potent monovalent vaccines, significant protection should be afforded by one injection. It is important that immunization be started as soon as

possible since about two weeks are required between immunization and maximal antibody response.

Besides immunization, staying out of situations in which large groups of people are crowded together seems to be the only other important measure for avoiding influenza. If symptoms of flu are noted, staying home will help prevent spreading the disease to others. Of course, maintenance of good personal nutrition and adequate rest can play a role in the prevention of many infectious diseases, and influenza should probably be included in this group.

Treatment of influenza is largely symptomatic except in the case of complications. □

New Appointments at State Board of Health

Pamela J. Bothe, *physical therapist, Community Health.*

Ruth L. Piesinger, *nutrition intern, Community Health.*

Wilton A. Williams, *public health investigator, Pesticide Program.*

Conrad C. Rich, *x-ray technician, Occupational Health.*

Sandra W. Pearce, *electrocar-*

diographic technician, Heart Unit.

Elmo John Pascal, *sanitarian, Sanitation Section.*

New Health Directors

Dr. Robert R. Albanese, *Acting Health Director, Tyrrell-Washington District.*

Dr. Roy G. Nation, *Acting Health Director, Wayne County.*

An Ancient Enemy

and

New Challenges

By C. Scott Venable

Executive Director

N. C. Tuberculosis and Respiratory Disease Association

Since last April the North Carolina Tuberculosis Association has officially been operating under the name of "North Carolina Tuberculosis and Respiratory Disease Association." That addition to the name means all it implies.

While the primary goal of the Association is still the eradication of tuberculosis, the new name gives us another dimension. New challenges have opened up, challenges that call for creative approaches to diseases such as emphysema, chronic bronchitis, asthma and

a host of other diseases that attack the respiratory system.

In keeping with our primary goal, the association has prepared to move ahead with the battle against tuberculosis. Education, demonstration of activities dealing with case detection and rehabilitation, and research will still play large parts in the association's overall tuberculosis program. Basic among these, of course, is education.

Experience has shown that a well-informed TB patient is one who is more likely to make an early and positive response to

his treatment. And a well-informed public is more likely to provide necessary services in the community. In order to bring about this understanding, the Tuberculosis and Respiratory Disease Association engages in investigation and analysis of the facts and interprets to the individual and the community the significance of these facts for needed action.

Pioneer Rule

Public health nursing and casefinding are among the demonstration projects which brought needed action to the battle against TB. Acting in the role of pioneer, the association helped prove the value of these projects to provide solutions where services did not exist or where other funds to support them were not available.

Another area in which the association is making a contribution to the health of the community is in research. The association is sponsoring research projects at the Duke University Medical Center, Bowman Gray School of Medicine, and the University of North Carolina School of Medicine. A select committee of experienced physicians screens the applications and makes the selection of the projects to be financed. This is in addition to the contribution sent yearly to the National Tuberculosis and Respiratory

Disease Research Fund.

Because of this continued support of research, new knowledge is becoming available for detection and treatment of tuberculosis. But it is vital that the association continue to work toward helping patients accept adequate treatment. Failure to use this knowledge could result in their becoming chronic sufferers of TB who continue to spread the disease.

While these programs are changing only as time and progress demand, the new challenges of other respiratory diseases are getting their share of the attention. These challenges are not entirely new to the association. For years the association has been involved in the attack on respiratory diseases other than tuberculosis. But now the association is looking to innovations in areas of patient education, case detection, inhalation therapy, physical therapy and emphysema clubs.

Film Education

A dramatic innovation in the field of other respiratory diseases is a patient education program developed through the cooperation of the State TB-RD Association and its medical section and the North Carolina Thoracic Society. Under the technical direction of Dr. Charles Edward Buckley III, president of the Thoracic Socie-

ty, the association has developed and produced a 14-minute patient education film on emphysema.

The concept has a two-fold purpose: (A) to free the individual physician from repetitive orientation of each patient on the basic knowledge that the patient needs to know; and (B) to provide a consistent and accurate description of the disease along with basic methods of controlling symptoms.

The film is designed specifically for the 8mm desk projector. The entire film presentation is contained in a cartridge much like the cartridges that radio stations have used for years in recording programs. When this cartridge is injected into the desk projector, the patient simply pushes a button and the presentation can be viewed on a built-in screen.

While a patient is watching a graphic illustration of his disease and the methods of controlling symptoms, the doctor can be freed to see additional patients. This innovation does not in any way damage the personal patient-doctor relationship. On the contrary, the relationship should be improved because the patient who has viewed a series of films on his disease can better understand the directions of his physician.

The next step is application

for additional funds from the Regional Medical Program to produce film clips in volume. Long range plans include the production of another general film and more specific films on subjects such as postural drainage, breathing exercises and intermittent positive pressure or "breathing machine" operation.

Emphysemas Anonymous

Through the leadership and direction of local TB-RD associations, emphysema clubs are springing up throughout the State. The emphysema club operates on the theory that many "anonymous" groups have used for years. Patients suffering from emphysema gather at a meeting place once a month and discuss their problems and exchange helpful ideas on how a particular problem was solved for them. The meetings give patients an outlet for their frustrations and they offer hope for chronically ill patients whose physical difficulties are accentuated by depression.

New and more imaginative approaches are being developed on the subject of cigarette smoking. Slide presentations, films and personal appearances by some of the nation's most outspoken critics of the cigarette habit are being taken into the schools of the State in an all-out effort to discourage

youngsters from getting the smoking habit.

These are only a few of the programs that are being developed to diversify the program of the North Carolina Tuberculosis and Respiratory Disease Association. But we have not forgotten our primary purpose,

and we don't intend to let up in the struggle against tuberculosis, one of the most stubborn diseases known to mankind. We are still very much in the fight against this ancient enemy and we hope to continue to find new ways of fighting until eradication has been accomplished. □

NUMBERS GAME

Sweden in 1749 was the first country in the world to conduct a census. The results were kept a state secret, because it was considered dangerous to reveal to foreign powers the small size of the population.

In 1947 Sweden established another "first" in population registration: the numbers system. Every Swede—man, woman, and child—has a nine-digit identification number, composed of his or her birthdate, sex, etc. By means of these numbers the government is assured of efficient and mistake-proof handling of voting, tax collection, social security, marriage, divorce, death, military service.

Only Israel and Holland have similar systems, while the rest of the world muddles along with names, sometimes allowing dead people to vote, women to lie about their age, awarding a pension to John Smithe instead of Smith.

To those who feel that society is becoming increasingly regimented, with a resultant loss in individuality, the head of Sweden's Bureau of Vital Statistics counters, "The numbers system is a tool that helps us to implement democracy, whereas I don't see anything at all democratic in the American way of doing things."

How It Was In The Old North State

COMPENSATION OF HEALTH OFFICERS

Resolved, by the conjoint session of the State Board of Health and the Medical Society of the State of North Carolina, in annual convention assembled, that the following fees for County Health Officers are a reasonable and equitable compensation for professional services rendered the public:

For post-mortem examination	\$10.00
Examination for lunacy	5.00
For monthly inspection of county institutions, jail, convict camp, and county home, each	4.00
For visits to sick inmate of county institutions, per visit	1.50
Mileage from court house .....	.50
Examination and treatment of more than one inmate on same visit .....	.50
For obstetrical work, per case	10.00
Surgical service regular fees, with discount of 33% for determining nature of a disease for quarantine officer other than himself	2.50
For sanitary examination of public school building	2.50
For medical inspection of school children, each .....	.40

Resolved, That county society be and is hereby requested to use its best endeavors to establish the above mentioned basis of fees.

Resolved, That in the opinion of this Society the life and health of our people are the greatest assets of our State.

Therefore, Be It Resolved, That every county in the State should employ its health officer for all his time.

Resolved, That in case a fixed amount per annum be paid the health officer in lieu of the above mentioned fees, we feel and believe that an amount equal to that received by the Sheriff of the county should be considered a minimum salary for his entire time.

L. B. McBRAYER,
WILLIAM McPHAUL,
L. N. GLENN,
COMMITTEE.

—*Transactions of the Medical Society of the State of North Carolina*
June 20, 22, 1911

Tuberculosis Control

In North Carolina

By Dr. Roy V. Berry

*Chief, Tuberculosis Control Section
North Carolina State Board of Health*

While the effects of tuberculosis on man, real or potential, can never be thought of as other than serious, notable advances have been made during the last two decades in controlling the incidence and spread of this disease.

Principally, this has been achieved with the aid of highly effective and relatively inexpensive antituberculous drugs. Provided they are properly taken, these drugs mean that better than 90 per cent of TB patients can return to their families

within a matter of a very few weeks or months. They can resume a productive life with the reassuring knowledge that their prospects of remaining non-infectious thereafter are very good.

The improved outlook for the newly diagnosed individual with active tuberculosis presupposes that he will undergo appropriate evaluation of his condition at the beginning of treatment and that he will remain under competent medical supervision for the remain-

der of his life. Caution in being over optimistic is necessary, however, since occasionally treatment does fail in spite of good management and a cooperative patient. Treatment failures are more numerous when patients are uncooperative. At times this may be caused or made worse by poor management on the part of the providers of services.

Instances where relapse or reactivation of tuberculosis occur bear witness to the need for physicians and other health workers to have a good understanding of the various possible effects of tuberculosis on man and for them in turn to impart much of this information to the patient, particularly the all important question of staying on drug therapy for the required period of time.

Hospitalization Important

Uninterrupted drug therapy is almost certain to be required for at least two years and in several instances for a longer period of time, perhaps indefinitely. It is important that the initial phase of the treatment program be carried out in the hospital and that the hospital have the necessary trained staff and facilities for managing the tuberculous patient. The question of infectiousness is only a part of this. Other reasons for initial hospitalization have to

do with getting adequate bacteriological investigations completed, including drug sensitivity tests; making sure the patient is able to tolerate the drugs selected for his treatment without untoward effects; demonstrating initial clinical improvement by chest X-ray or other means; and, while these things are going on, educating the patient to the vital need of understanding that his tuberculosis will not be brought under control unless he continues drug treatment after leaving the hospital for the prescribed period of time.

Some adjustments in the patient's mode of life after he leaves the hospital may also be necessary if he is to remain well. These do not ordinarily prohibit him from engaging in most types of work, and any adjustments necessary usually relate to the need to live a well ordered and not overly stressful life. This is not always suitable and is one reason why periodic clinical evaluations are important on an indefinite basis for the ex-tuberculous patient.

Many new active cases of tuberculosis occur in individuals infected some years earlier without the necessity of recent exposure. Recognition of this fact has rendered the approach to more effective control of tuberculosis a rational one. The

knowledge that persons with close contacts to active cases, especially children, are highly susceptible to infection or disease, or both, clearly points the way to yet further improved control. The main objective in achieving effective tuberculosis control is to reduce to a minimum the opportunities for the disease to spread from one person to another. Thus, one of the major new tasks becomes the identification of the infected (latent cases) and the preventive treatment of those at highest risk of developing tuberculous disease. This approach, together with prompt contact investigation which by and large is well done, can become the needed impetus toward reaching the goal of ultimate eradication of tuberculosis as a health hazard to the residents of North Carolina or any other State.

Control Program

Involved in a tuberculosis control program are tuberculin skin testing, screening and diagnostic; chest X-rays; adequate records procedures, including a register of cases; hospitals for the initial treatment of cases; and local chest clinics with adequate staffs and facilities for the diagnosis, post-hospital supervision of treatment, and long term periodic follow-up of cases. Activities of a chest clinic also include the medical and nurs-

ing supervision necessary for those persons identified for preventive treatment, such as infected young children, recent tuberculin converters, and close contacts to infectious cases.

In short, trained personnel, money, equipment, hard work, and a well conceived and executed program are needed for any community having any degree of high tuberculosis incidence within its confines if the disease is ultimately to be eliminated as a health hazard. Concentration of effort in high prevalence areas has priority but it cannot finish the job. Sustained efforts in all areas are necessary. The tools for further significant reduction of tuberculosis are at hand. The time to be applying them is now.

State Resources

Resources available from the State of North Carolina are designed to relieve and assist local health departments achieve satisfactory standards of tuberculosis control in their respective areas. There are five major resources at the State level:

1. In-patient and out-patient facilities at the four sanatoria comprising the North Carolina State Sanatorium System. These hospitals are located at Chapel Hill (Gravely), McCain, Wilson and Black Mountain. Any

person in North Carolina known or suspected to have tuberculosis can be admitted to one or other of these hospitals for investigation and treatment without regard to financial ability to pay. Clinician services for county chest clinics are provided by staff members. The System also provides tuberculin (PPD-S) and anti-tuberculous drugs on a cost basis to local health departments.

2. Consultative services from the Tuberculosis Control Section, Division of Epidemiology, North Carolina State Board of Health, in the areas of:

- a) Epidemiology and Program Development and Evaluation.
- b) Public Health Nursing in relation to Tuberculosis.
- c) Records Procedures and Tuberculosis Care Registers (available from Public Health Records Unit, Community Health Division).

3. Financial assistance for the expansion and improvement of local control programs through the United States Public Health Service Special Tuberculosis Control Project Grant Award to the North Carolina State Board of Health. The level of support under this project, cur-

rently \$650,000 per annum, has reached its anticipated maximum. There are now forty counties receiving continuous support under this project.

4. Mobile chest X-ray clinic services. This program, available to local health departments and certain State agencies from the Tuberculosis Control Section, North Carolina State Board of Health, now consists of the operation of a single newly equipped, fully mobile and self-contained combined 14 x 17 and 70 mm clinic unit for limited intensive casefinding surveys in known or suspected high prevalence areas anywhere within the State. As circumstances permit, it is also available for assistance in reducing any backlog of definitive chest X-ray work in respect of contacts, suspects and known inactive tuberculous patients in health departments unable to complete this work from their own or other local resources.
5. Supply, as funds permit, of certain tuberculin skin testing materials from the Tuberculosis Control Section, North Carolina State Board of Health, to local health departments at approximately fifty percent of cost. □

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Physicians Seek Better Services For Handicapped Children

Around 100 pediatricians, psychiatrists, orthopedics specialists and family doctors from throughout North Carolina attended a fall seminar in Raleigh to explore ways of improving medical services to handicapped children in the State.

Dr. Robert B. Kugel, a member of the President's committee on mental retardation and professor of pediatrics at the University of Nebraska, discussed frontiers in the management of handicapped children.

Other topics covered were newer psychological approaches

to evaluation of handicapped children, the physician's approach to counseling parents of handicapped children, needed resources in North Carolina, and continuing education for physicians.

The seminar was sponsored by the maternal and child health and crippled children sections of the State Board of Health, and the departments of pediatrics of the Bowman Gray, Duke University and University of North Carolina Schools of Medicine. ☐



THE
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December 1968

Score for Dental Health

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NOTE: This abbreviated issue of *The Health Bulletin* will be followed by another small edition next month.

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Editor: H. B. Rogers

Vol. 83 December 1968 No. 12

Cover: An intent young miniature golfer scores at the State Board of Health's exhibit at the N. C. State Fair in October. He was one of many hundreds of youngsters who played.

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Young Golfers Score For Healthy Teeth

North Carolina
STATE BOARD
of
HEALTH...



Some 6,000 youngsters, from toddlers to teenagers, played miniature golf at the North Carolina State Fair in October—and picked up some pointers for healthy teeth at the same time. They were guests at the State Board of Health's exhibit.

The exhibit was a four-hole miniature golf course laid out to promote the four rules for having healthy teeth:

- Fluorides
- Nutrition
- Toothbrushing
- Care by a dentist

At the end of each hole was a sign board with a dental health rule printed on it. Whenever a player scored on the hole, the sign board lit up and a siren sounded, or bells rang, to let everybody know.

The exhibit was located on the lower level of the Dorton Arena. It was open from 10 a.m. Monday through 6 p.m. Saturday.

Volunteers from the administrative staff of the State Board of Health acted as attendants.

The exhibit was designed and built by members of the staff of the Dental Health Division. Dr. E. A. Pearson Jr. is division director.



Co-recipient of the WATSON S. RANKIN AWARD in recognition of outstanding contributions to public health in North Carolina over a period of many years was Mrs. Maxine Matheson of Raleigh. The other recipient was Thomas W. Bivens of Charlotte.



State Senator Marshall Rauch of Gaston County was co-recipient of the DISTINGUISHED SERVICE CITATION, given to non-member individuals. He shared the award with Robert Conn, assistant city editor of the Charlotte Observer.

Mrs. Mary Edith Duncan Rogers of the Gaston County Health Department received the CARL V. REYNOLDS AWARD, which goes to an individual "for outstanding contributions to public health in North Carolina during the past year and for meritorious service above and beyond the call of duty." The Reynolds Award, oldest given by NCPHA, is one of the organization's highest honors. Reading the citation for Mrs. Rogers is Dr. W. Fred Mayes, dean of the School of Public Health at the University of North Carolina at Chapel Hill.



Mrs. Lucille W. Jenkins of the Randolph County Health Department shared the MERIT CITATION AWARD for outstanding work in her role as fulltime public health worker. Co-recipient was Anne Parrish of the State Board of Health.



For outstanding contributions to public health, the GROUP MERIT AWARD went to the Air Pollution Control Section, Environmental Health Division, Mecklenburg County Health Department. W. L. Dentler, director, accepted the bronze plaque.



Ben Eaton of Raleigh (left), outgoing NCPHA vice president and outgoing President Dr. Maurice Kamp of Charlotte at convention awards banquet.

NORTH CAROLINA PUBLIC HEALTH ASSOCIATION

Public health workers from throughout North Carolina got together in Charlotte in October to attend professional meetings and workshops and to grant recognition to their own for distinguished accomplishments.

The occasion was the 57th annual meeting of the North Carolina Public Health Association, held at the White House Inn October 9-11. Meeting at the same time were the N. C. Academy of Preventive Medicine and Public Health and the N. C. Conference of Health Directors.

Highlights of the meeting were the awards banquet and the election of new officers to serve in 1969.

New president is Dr. E. A. Pearson Jr. of Raleigh, director of the Dental Health Division of the State Board of Health. President-elect is C. Scott Venable of Raleigh, executive director of the N. C. Tuberculosis and Respiratory Disease Association.

Other officers are Mrs. Winston S. Shull of Shelby, vice president; Jane Davies of Raleigh, secretary; and Mrs. Margaret Bryant of Raleigh, treasurer.



Miss Davies, Mrs. Bryant and Mrs. Shull (left to right, seated) and Mr. Venable, Dr. Pearson and Immediate Past President Dr. Kamp (standing).

Twenty Years of Service

THE ARTHRITIS FOUNDATION

BY ROBERT PACE

*Executive Director,
North Carolina Chapter*

Arthritis is the oldest known crippling disease. It afflicted prehistoric man, was present even in "the land of milk and honey," and today, despite the advances of modern medicine, remains the greatest crippler of mankind. Its cause or causes remain unknown and no cure has been found. It presently afflicts 16,800,000 Americans and 446,000 folks in our own Tar Heel State.

The Arthritis and Rheumatism Foundation was formed in 1948 by Floyd B. Odum as a means of focusing public attention on the problem and raising funds for research that would enable better care and treatment for arthritis victims and, hopefully, discover the cause and cure.

In 1948 few people were concerned about the problem of arthritis or doing anything

about it. Today there are hundreds of physicians and scientists engaged in research projects; thousands of physicians, nurses, and therapists with knowledge that enables them to provide more effective treatment; and thousands of volunteers who make possible the work of The Arthritis Foundation throughout the nation.

In 1964, the North Carolina Chapter of the Arthritis and Rheumatism Foundation was chartered in North Carolina and an office opened in Chapel Hill. Mrs. W. Kerr Scott, a former First Lady of the State, served as Honorary Chairman of the Chapter; Dr. Donald D. Weir of North Carolina Memorial Hospital served as Chairman of the Board of Directors; and Mrs. Coleman Carter, a prominent leader in many organizations, served as Chapter President. Prominent business men such as Irwin Belk and S. H. Mitchell gave active support to the Chapter.

Today, the name has been shortened to The Arthritis Foundation. There are active

volunteer groups in 25 counties and chapter income should be \$100,000.00 for the present fiscal year. Mrs. Dan K. Moore is Honorary Chairman of the Chapter; the Honorable John R. Jordan, Jr. of Raleigh is Chapter President; and Dr. Weir continues as Chairman of the Board of Directors. Many prominent Tar Heels serve as Sponsors for the Chapter.

The first emphasis of The Arthritis Foundation remains on research, for this will one day result in a real breakthrough—a cure for arthritis. The first emphasis of the North Carolina Chapter is public and professional education. Public education focuses attention on the problem and professional education brings to the attention of the physician, the nurse, the therapist, and the patient the advances in care and treatment that can prevent crippling in most cases. The Chapter seeks and needs the active interest and support of every citizen of North Carolina. □

Glenn Flinchum, chief of the Public Health Statistics Section of the North Carolina State Board of Health, whose remarks about a "numbering system" in the United States appear on the back cover, will have an informative article dealing with vital statistics in North Carolina in a forthcoming issue of THE HEALTH BULLETIN.

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NUMBERS GAME—Continued

Editors' Note: In our last issue we ran a brief article about population registration in Sweden. Every Swede has a nine-digit identification number, coded to show the individual's birth-date, sex, and other pertinent information.

Our article caught the eye of Glenn A. Flinchum, chief of the Public Health Statistics Section of the North Carolina State Board of Health, and he was quick to respond. His letter to the editor follows.

In regard to the numbering system used in Sweden, there is a similar identification system in the United States which is available to those agencies and organizations wishing to make use of it. It is the number which appears on the birth certificate of every child born in the United States. Each individual has his own birth number which will not be duplicated within 100 years. It consists of eleven digits, the first three digits identifying the state of birth, the next two the year, and the last six the registration number.

North Carolina adopted this method of numbering births in 1944, shortly after it was developed by the Public Health Service. Some states, however, were much slower to come into the system. It was not until January 1, 1968 that all states were using the birth number in its entirety.

Many Groups and organizations are interested in making use of the birth number, particularly in regard to record linkage. Now that it has become nationwide, we have the capability of eventually following Sweden's example. ☐





